

General Information, Eligibility, and Entitlement Manual

Chapter 7 - Contract Administrative Requirements

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30 - Files Maintenance

(Rev. 38, Issued: 05-26-06, Effective: 06-26-06, Implementation: 06-26-06)

30.10 - Files Maintenance Program - General

(Rev. 38, Issued: 05-26-06, Effective: 06-26-06, Implementation: 06-26-06)

Subject to the provisions of the Code of Federal Regulations, Title 41, Part 102 – Creation, Maintenance and Use of Records, http://www.access.gpo.gov/nara/cfr/waisidx_05/41cfr102-193_05.html CMS has the responsibility for the development and implementation of standards and programs for the economical management of records under the health insurance program. Specifically, CMS is required to provide for effective controls over the creation of records, including the making of records containing adequate and proper documentation of the contractor's administration and operations. Each contractor is required to establish and maintain an active, continuing program for the economical and efficient management of the records outlined in §30.20.

The contractor's programs must provide for:

- Effective controls over the creation, the organization, maintenance and use, and disposition of all CMS health insurance claims and non-claims records; and
- Development and application of standards, procedures, and techniques designed to assure the maintenance and security of records of continuing value and facilitate the disposal of all records of temporary value.

The contractor provides for the continued analysis and improvement of record classification and indexing systems, the use of filing equipment and supplies, and the reproduction and transportation of records. The contractor assures that records are maintained economically and efficiently for maximum usefulness.

The files established by the contractor, and all records and procedures documenting its programs for controlling the creation, maintenance, and use of current records, for the selective retention of records of continuing value, and for the disposal of noncurrent records, must be available for periodic review by CMS.

Under no circumstances are any records identified by CMS as relating to a current investigation or litigation/negotiation by the Office of the Inspector General or the Department of Justice, ongoing Workers' Compensation, set aside arrangements, or documents which prompt suspicions of fraud and abuse of overutilization of services to be destroyed. These records must be retained until you receive authorization from CMS.

30.10.1 - Description of Records Maintained

(Rev. 38, Issued: 05-26-06, Effective: 06-26-06, Implementation: 06-26-06)

A - Claims Records

These are Government records including Government-issued standard forms and other forms, documents, and statements needed to support claims. Such records are maintained by the

contractor in accordance with instructions regarding retention, transfer, destruction, and other disposition of claims materials. (See §§30.30 and 30.40.)

B - Non-Claims Records

These include materials not needed as supporting documentation of a claim, such as used work sheets, extra copies of documents, retained CMS bill copies where records were submitted on tape, used punched cards, EDP listings, used paper tape, and general correspondence not related to specific pending or processed claims. See §30.30 for the records retention and disposal schedule and §30.70 for the disposition of such material.

C - Fiscal and Administrative Records

These include records that are not included as claims or non-claims records. See §30.70 for the records retention and disposal schedule.

D – Microform Records

This is a term used for any form containing micro-images (e.g., microfilm, microfiche). If records are microfilmed, the original records must still be retained.

E – Scanned/Imaged Records

This is a term used for any information that is recorded in a form that only a computer can process. This is the preferred format when paper records are not retained. The image becomes the “official record/recordkeeping copy” which must be retained in accordance with directives from CMS.

30.10.2 - Definition of a Record

(Rev. 38, Issued: 05-26-06, Effective: 06-26-06, Implementation: 06-26-06)

Records are basically files consisting of papers, folders, photographs, photographic copies, magnetic tapes, or other recorded information regardless of physical form or characteristics, accumulated or maintained in filing equipment, boxes, disks, CDs or shelves, and occupying office or storage space. Stocks of publications and blank forms are not included in this definition.

30.20 - Implementing a Files Management Program

(Rev. 38, Issued: 05-26-06, Effective: 06-26-06, Implementation: 06-26-06)

Adequate records management controls over the creation of contractor files must insure that important policies and decision are adequately recorded, routine operational paper work is kept to a minimum, and the accumulation of unnecessary files is prevented. Effective techniques in this area include the application of systems for the control of correspondence and forms, the minimizing of duplicate files, and the disposal without filing of transitory material that has no value for record purposes.

CMS expects each contractor to establish an appropriate program for the management of its files. The following actions are generally basic to such a files management program.

A. Standardize classification and filing schemes to:

1. Achieve maximum uniformity and ease in maintaining and using program records;
2. Facilitate disposal of records in accordance with applicable records disposal schedules;
and
3. Facilitate possible later consolidation of identical type files presently maintained at different locations.

B. Formally authorize official file locations. Prohibit the maintenance of files at other than authorized locations.

C. Standardize reference service procedures to facilitate the finding, charge-out, and refiling of records.

D. File accumulations of papers received at file locations on a daily basis.

E. Audit periodically a representative sample of the files for duplication, misclassification, or misfiles.

In addition to the above, the contractor's program must:

A. Establish and implement standards and procedures issued by CMS. Such CMS standards and procedures relate to:

1. Classifying, indexing, and filing records;
2. Providing reference services to filed records;
3. Locating active files to facilitate use of the records; and
4. Reviewing the program periodically to determine the adequacy of the system and its effectiveness in meeting requests.

B. Ensure that the standards, guides, and instructions developed for the files management program are readily available to all employees concerned with the files operations. In addition, give pertinent information for users of files and references services the widest possible dissemination.

C. File accumulations of papers received at file locations on a daily basis.

D. Audit periodically a representative sample of the files for duplications, misclassification, or misfiles.

The methods used in maintaining, using, and disposing of these files vary with the contractor. Variations depend on the filing and control methods established (e.g., provider number, health insurance claim number, date, name, or other sequence) to record requests from providers; to

furnish replies; to check on overdue cases; to control cases for completion of processing; to control cases requiring some type of investigation or additional documentation; to retain completed cases for history or other reference; to maintain for audits; and to schedule for transfer to other storage areas. Other variances may be due to computer or clerical practices; workload volume; review initiated at time of notice of admission, at time of start of care, at time of request for advance payment or at time of receipt of billing form; and other considerations.

30.30 - Record Retention and Disposal Schedule

(Rev. 38, Issued: 05-26-06, Effective: 06-26-06, Implementation: 06-26-06)

This schedule identifies those records accumulated by the contractor in administering the Medicare program and outlines the disposal schedule for each type of record.

A freeze has been imposed on the destruction of Medicare records. No paper Medicare records can be destroyed unless they are electronically imaged. If Medicare records are not imaged, the original paper document must be retained. A contractor who images paper Medicare records:

1. Must always be able to demonstrate the imaged version is an exact copy of the paper document,
2. Document the steps taken to image the original document,
3. Establish and implement a certification/quality assurance process to ensure the imaged information is an identical replication of the paper document in every way,
4. Retain the scanned image as the "recordkeeping copy" for the required retention period, and
5. Maintain accessibility and the ability to read the document in accordance with changes in technology.

The methods used in imaging files may vary with the contractor. These variations depend on the type of equipment used and methods used to prepare documents for imaging. All imaged documents shall be tamper proof. Once an image is verified as an exact copy of the original paper document, only then can the original paper document be destroyed and the imaged copy is certified as the "recordkeeping copy".

Certifying images as an exact copy of the paper document means there is a "quality assurance" process in place that verifies that the images are good. Each contractor is responsible for establishing their own "quality assurance" procedures.

Below is an example of a certification/quality assurance process.

1. The staff member performing the actual scan will:
 - a. Observe that all pages successfully pass through scanner and that image displayed on the imaging software preview screen appear accurate.

- b. Affix a sticker marked “Scanned” to the top page, write the current date on the sticker and place on top of a pile of scanned material.
2. The staff member(s) responsible for these records will have immediate access to the images, from their desktops, using the imaging software. They will have 30 days to use and review the images. If any problem is detected, the paper will be retrieved and rescanned. After 30 days, the paper copies are subject to proper disposal.

A contractor is authorized to cut off and transfer Medicare claims records and other records to inactive storage earlier than is prescribed in the disposal schedule shown below when the records are contained on microform. (See §§40.3 and .50ff. for guidelines on retention and disposition guidelines on microform copies of the following records.)

The term "cut off" means the transfer of records to an inactive files area when there is no more than one reference to a file drawer per month. See §§30.70 for guidelines regarding the disposition of non-claims material not transferred to inactive storage.

30.30.1 - Disposition Instructions – Destruction of Records (Rev. 38, Issued: 05-26-06, Effective: 06-26-06, Implementation: 06-26-06)

In accordance with Federal regulations, 36 CFR 1228.58(b)-Destruction of Temporary Records, http://www.access.gpo.gov/nara/cfr/waisidx_05/36cfr1228_05.html paper records to be disposed of normally must be sold as wastepaper. Because the records you maintain are considered restricted, you are required to pulp, macerate, shred, or otherwise definitely destroy the information contained in the records and their destruction must be witnessed by you who created the records or by a contractor employee (see Exhibit 11, Witness Disposal Certification-Sample). The contract for sale must prohibit the resale of all other paper records for use as records or documents. Regardless of medium, records other than paper records (e.g., audio, visual, data tapes, disks, diskettes, etc.) may be salvaged and sold in the same manner and under the same conditions as paper records.

A Witness Disposal Certification must be completed and kept on file for 7 years.

30.30.1.1 - Disposition Instructions When Operating Under a Freeze (Rev. 38, Issued: 05-26-06, Effective: 06-26-06, Implementation: 06-26-06)

When operating under a freeze, you are prohibited from destroying records, and must follow the disposition instructions below in §30.30.1.2. Only after the freeze has been lifted, can you revert back to the normal disposition instructions in §30.30.2.

30.30.1.2 - Disposition Instructions When Medicare Records are Microfilmed (Rev. 38, Issued: 05-26-06, Effective: 06-26-06, Implementation: 06-26-06)

Paper Records

All paper claims that are microfilmed must be retained until CMS notifies you the freeze is lifted.

Microform Records

The master microform must be retained until CMS notifies you the freeze is lifted.

30.30.1.3 - Disposition For Paper-Only Medicare Records (Rev. 38, Issued: 05-26-06, Effective: 06-26-06, Implementation: 06-26-06)

The contractor cuts off the file at the close of the calendar year in which the claim was paid, then transfers the paper records to inactive storage. The paper records must be retained until CMS notifies you the freeze is lifted.

30.30.1.4 - Disposition For Medicare Records that are Imaged/Scanned (Rev. 38, Issued: 05-26-06, Effective: 06-26-06, Implementation: 06-26-06)

Paper

Since imaging can be used to replace paper documents, only when the image will be identical to the paper, you must image/scan both the front and the back of every document.

There is an exception: **Once the back of a claim form is imaged, you do not have to image the back of the rest of the documents imaged on that particular machine, as long as the backs are identical and a certified statement is kept on file stating “the remainder of the backs of the claim forms are identical”. However, if the back of a claim form differs in any respect, it must be imaged.**

The contractor must retain the paper records until their certification/quality assurance process (see below) has been completed and the imaged information (the recordkeeping copy) is verified as an identical replication of the paper document. Only then can the paper records be destroyed.

If a scanned document is not identical to the paper document, that paper document must be retained until the freeze is lifted.

Imaged/Scanned Records

Due to the freeze prohibiting the destruction of Medicare records, do not destroy any images of claims records. They are the recordkeeping copy and must be retained until CMS notifies you the freeze is lifted. Once the freeze is lifted, revert back to the normal disposition instructions in §30.30.2.

Sample Quality Assurance Procedure

Certifying images as an exact replication of the paper document means there is a "quality assurance" process in place that verifies that the images are good. Each contractor is responsible for establishing their own "quality assurance" procedures. Below is an example of a quality assurance process.

Standard Procedures for Document Imaging Quality Assurance

- 1. The staff member(s) performing the actual scan will:**

- a. **Observe that all pages successfully pass through scanner and that image displayed on the imaging software preview screen appear accurate.**
 - b. **Affix a sticker marked “Scanned” to the top page, write the current date on the sticker and place on top of a pile of scanned material.**
2. **The staff member(s) responsible for these records will have immediate access to the images, from their desktops, using the imaging software. They will have 30 days to use and review the images. If any problem is detected, the paper will be retrieved and rescanned. After 30 days, the paper copies are subject to proper disposal.**

30.30.1.5 - Disposition for Medicare Records When Potential Fraud or Overutilization has been Identified

(Rev. 38, Issued: 05-26-06, Effective: 06-26-06, Implementation: 06-26-06)

When potential fraud or overutilization has been identified, retain the recordkeeping copy onsite. If the recordkeeping copy has already been transferred to offsite storage, retrieve and retain onsite until the investigation and subsequent legal action, if any, has been completed (including the exhaustion of all appeals), then destroy 3 months thereafter.

If at the close of this period, the disposition instructions shown in §30.30.1.1 through 30.30.2 remains applicable, retain, transfer, and destroy in accordance with the disposition instructions. If the disposition instructions in §30.30.1.1 through 30.30.2 are no longer applicable, then destroy after the 3 month period following completion of the investigation or subsequent legal action, if any.

If any records are provided to a prosecutorial agency as evidentiary matter, consider such records as disposed of. If any such record is returned by the prosecutorial agency, retain for 3 months, then destroy in accordance with the foregoing disposition instructions unless otherwise directed by the prosecutorial agency.

30.30.1.6 - Disposition for Medicare Records Already in Storage

30.30.2 - Description of Records

(Rev. 38, Issued: 05-26-06, Effective: 06-26-06, Implementation: 06-26-06)

1. Medicare Claims Records:

A. FI Billing Records (FROZEN – DO NOT DESTROY)

These files consist of Inpatient and/or Outpatient Billing forms, and other documents used to bill for services processed by FIs; i.e., inpatient hospital, outpatient hospital, SNF, hospice, home health, etc.

DISPOSITION: Once the freeze is lifted, cutoff at the close of the CY in which paid. Destroy 6 years and 3 months after cutoff.

B. Carrier Billing Records (FROZEN – DO NOT DESTROY)

These files consist of Requests for Payment and similar forms. Also included are itemized bills, correspondence (including correspondence with district offices), and comparable documents used to support payment to beneficiaries, physicians, and other suppliers of services under the Supplemental Medical Insurance (SMI) Program.

DISPOSITION: Once the freeze is lifted, cutoff at the close of the CY in which paid. Destroy 6 years and 3 months after cutoff.

2. Medicare Benefit Check Records (FROZEN – DO NOT DESTROY)

These files consist of paid checks that contractors receive from banks covering amounts paid to providers of service, beneficiaries, physicians, and other suppliers of service under the Hospital Insurance and Supplementary Medical Insurance (SMI) programs. Also included are check vouchers and cancelled or voided checks resulting from nonreceipt, loss, theft, or non-delivery.

Disposition:

The contractor cuts off the file at the close of the calendar year in which issued, holds the file for 1 additional year, and then transfers it to inactive storage. Once the freeze is lifted, the file is destroyed after a total of 6 years and 3 months retention.

When fraud or overutilization of services is involved, the contractor retains the hard copy claim until 3 months after the resolution of the investigation OR reverts to normal disposition, whichever is longer.

3. Medicare Summary Notices (MSNs) (FROZEN – DO NOT DESTROY)

These files consist of MSNs used to advise beneficiaries about remaining Part A benefits, Part A and Part B deductible status, and about applying for complementary health benefits.

Disposition: The contractor cuts off the file at the close of the calendar year in which benefit was paid or denied, as applicable, holds for 1 additional year and then transfers to inactive storage. Once the freeze is lifted, remove them from inactive storage for destruction after a total of 6 years and 3 months retention from cut off.

4. Reconsideration and Hearing Case Files - Hospital Insurance Program (FROZEN – DO NOT DESTROY)

Reconsideration records accumulate when a beneficiary or their representative is dissatisfied with the FI's determination denying payment, or with the amount of benefits payable on the beneficiary's behalf under the Hospital Insurance Program and files either an expressed or implied request for reconsideration. Hearing case records accumulate when a beneficiary or their representative is dissatisfied with the reconsideration determination and requests a hearing; and if still dissatisfied after the hearing, files for a subsequent court review. Included are Forms CMS-2649, Request for Hearing; CMS-561, Request for Reconsideration; or their equivalents. Also included are evidence furnished by beneficiaries or their representatives, correspondence, CMS determinations, Administrative Law Judge decisions, original bills, Appeals Council decisions and similar material.

Disposition: Once the freeze is lifted, the contractor disposes of these records in accordance with instructions for Medicare claims records.

5. Review and Fair Hearing Case Files - Supplementary Medical Insurance Program (FROZEN – DO NOT DESTROY)

This category includes files accumulated when a beneficiary, physician, provider, or other supplier of service is dissatisfied with the FI or carrier's determination denying a request for payment, or with the amount of the payment, or with the reasonable promptness of action on a request for payment. Included are copies of claimant's requests for review, relevant written statements or evidence, notices of adverse formal review decisions, requests for hearings to protest the adverse decisions, hearings proceedings, hearing officers' final decisions, and other comparable papers.

Disposition: The contractor places these records in an inactive file upon final action on the case. It cuts off the inactive file at the close of the calendar year in which the final action was taken, and holds it for 2 additional years, then transfers it to off-site storage. Once the freeze is lifted, these records can be destroyed when 5 years old.

6. FI and Carrier Administrative Budget Estimate and Cost Report Form (FROZEN – DO NOT DESTROY)

These files consist of all uses of the Administrative Cost and Budget Report, CMS-1523 for carriers and CMS-1524 for intermediaries. This form is a multi-use document and issued for budget and cost reporting activities.

Specific uses are:

a. Budget request, supplemental budget request, notice of budget approval, interim expenditure report.

Disposition: Once the freeze is lifted, destroy after a total retention of 3 years after HHS audit and final settlement.

b. Supplemental Budget Request

Disposition: Once the freeze is lifted, destroy after a total retention of 3 years after HHS audit and final settlement.

c. Notice of Budget Approval – The carrier/intermediary's certified funding authority for the fiscal year. Include all supporting schedules, correspondence and justification.

Disposition: Once the freeze is lifted, destroy after a total retention of 3 years after HHS audit and final settlement.

d. Interim Expenditure Report – Cumulative fiscal year to date expenditures incurred by the carrier/intermediary. Include all supporting schedules, correspondence and justifications.

Disposition: Once the freeze is lifted, destroy after a total retention of 3 years after HHS audit and final settlement.

e. Final Administrative Cost Proposal – The final statement of expenditures for the fiscal year. This form is used as the basis for final settlement of allowable costs. Include all supporting schedules, correspondence, HHS or GAO audit reports on administrative cost and benefits payments.

Disposition: Once the freeze is lifted, destroy after a total retention of 6 years and 3 months after HHS audit and final settlement.

7. FI and Carrier Letter of Credit Files (FROZEN – DO NOT DESTROY)

These records are authorizations to a Federal Reserve Bank to disburse funds to designated FIs and carriers' banks on behalf of CMS upon presentation of request for funds for collection through the Federal Reserve System. Included are Standard Form 1193, Letter of Credit or its equivalent, and amending letters.

Disposition: Once the freeze is lifted, destroy after a total retention of 6 years and 3 months after the year in which the letters of credit are cancelled.

8. FI Payment Vouchers and Transmittal Files (FROZEN – DO NOT DESTROY)

These consist of Form TFS-218, Request for Funds, and similar documents prepared by the FI's servicing bank to obtain Federal funds for benefits paid in administering medical insurance programs. Also included is Form CMS-1521, Payment Voucher on Letter of Credit, a transmittal that forwards information on request for funds to CMS and shows the purpose for which funds were drawn, i.e., hospital insurance benefits, supplementary medical insurance benefits, and total amount of payment vouchers.

Disposition: Once the freeze is lifted, destroy after a total retention of 6 years and 3 months or after HHS audit and final settlement, whichever is later.

9. FI and Carrier Payment Vouchers and Transmittal Files (FROZEN – DO NOT DESTROY)

These files consist of form TSF-5805, Request for Funds, and similar documents prepared by the carrier's servicing bank to obtain Federal funds for benefits paid in administering medical insurance benefit programs. Also included is Form CMS-1521, Payment Voucher on Letter of Credit Transmittal, a transmittal that forwards information on request for funds to CMS and shows the purpose for which funds were drawn, i.e., SMI benefits and total amount of payment vouchers.

Disposition: Once the freeze is lifted, destroy after a total retention of 6 years and 3 months or HHS audit and final settlement, whichever is later.

10. FI and Carrier Monthly Financial Report Files

These are reports submitted monthly to provide CMS with the basic data to reconcile CMS's accounts with those that contractors maintain. Included are Form CMS-1522, Monthly Intermediary Financial Report and attachments.

Disposition: Destroy after HHS audit and final settlement.

11. Carrier Performance Report Files

These consist of Forms CMS-1565, Health Insurance for the Aged Program Carrier Performance Reports, and equivalent documents prepared monthly summarizing each carrier's performance in processing claims. The information provides management information needed for budgeting, financing, work planning, performance evaluation, and identifying operating problems.

Disposition: Destroy after 3 years.

12. Ambulance Supplier Certification Files

These consist of certifications of suppliers of ambulance services.

Disposition: Destroy 1 year from the end of the year when certification requirements are no longer met.

13. Requests for Assistance from District Offices (DOs) (FROZEN – DO NOT DESTROY)

These consist of correspondence and forms submitted to the DO for development of additional information or documents relating to a Medicare claim, e.g., incorrect name or claim number and similar errors that prevent the processing of a claim.

Disposition: Once the freeze is lifted, dispose of in accordance with instructions for claims records.

14. FI Workload Reports Files

These consist of monthly statistical reports on the status of FI workloads used by CMS to identify basic management data needed for budgeting, financing, work planning, and progress evaluation. Included is Form CMS-1566, Health Insurance for the Aged Program FI Workload Report, or equivalent documents.

Disposition: Destroy after 3 years.

15. Overpayment and Duplicate Charge Detection Activity Report Files – Carrier Report

These consist of quarterly reports summarizing overpayment and duplicate charge detection activity. They are used to tabulate data on the number of cases in which overpayments are recovered, the total dollar amount of money overpaid, causes of overpayments, number of duplicated charges detected, and similar information.

Disposition: Destroy after 3 years.

16. Medicare Beneficiary Correspondence Files (FROZEN – DO NOT DESTROY)

These accumulate as a result of inquiries and complaints received by CO, RO, and contractors and **do not** include any correspondence that is related to a claim file.

Disposition: Destroy 3 months after the date of the response to the correspondence. If a response is not required, the contractor destroys the material 3 months after the date of the correspondence.

Where the material documents a specific claim, appeal, or similar case, the contractor follows the instructions for claims records.

17. FI and Carrier Contract Files

These consist of agreements entered into with FIs and carriers by the Secretary under the provisions of §§1816 and 1842 of the Act by which FIs and carriers agree to perform certain functions in administering the Hospital Insurance and Supplementary Medical Insurance programs. As such, they provide basic documentation of the manner in which these programs are implemented. Included are modifications and amendments.

Disposition: Destroy 3 years after supersession or termination, as applicable.

18. FI and Carrier Subcontract Files

These consist of copies of FI and carrier agreements with subcontractors regarding performance of an audit of providers' costs (FIs), leases for building space, equipment, and consulting and other services. Included are CMS approvals, amendments, and similar papers.

Disposition: Destroy 3 years after termination of agreement.

19. Contract Performance Review Visit Files

These consist of documents relating to scheduled or special visits to Medicare contractors to review your Medicare operations, to determine the degree of adherence to established policy and adequacy of service to the public, and to verify the accuracy of reporting. Included are reports of staff visits, follow-up reports, communications concerning improvements in operations, and any other related documents.

Disposition: Destroy 4 years after the close of the calendar year in which action on the review is completed.

20. FI and Carrier Computer Printout Records (FROZEN – DO NOT DESTROY)

These consist of computer printouts used in processing, paying, and controlling Medicare claims.

a. Pending and process listing, payment listing, duplicate check control, master file update control, and profiles of physicians and other suppliers of services.

Disposition: Once the freeze is lifted, destroy 4 years after the close of the calendar year in which payment was made.

b. Check listing and bank reconciliation.

Disposition: Once the freeze is lifted, destroy 6 years after the close of the calendar year in which paid or voided.

c. CWF inquiry or response listings, transaction listing, activity listings, posting exceptions, analysis of posting errors, claims inventory control, edit input transactions, and aging of open claims.

Disposition: Once the freeze is lifted, destroy 3 years after processing. (Contractors with the capability of electronically retaining the CWF data may destroy the paper copies after the tapes have been verified.)

21. FI Cost Report Files (FROZEN – DO NOT DESTROY)

These consist of cost reports submitted by providers to FIs for determining Medicare reimbursable costs in accordance with regulations and the principles of reimbursement. The cost report file includes: (a) a copy of the original cost report form as filed by the provider; (b) copies of all decisions made by field auditors, including those subsequently reversed by senior auditors; (c) a copy of the Audit Adjustment Report; (d) a copy of revised cost report schedules (or a revised cost report); (e) a copy of the notice of program reimbursement; (f) a copy of the audit report when prepared by the FI staff accountants and the supporting audit working papers.

Disposition: The FI maintains the cost report on premises for 3 years after the Notice of Amount of Medicare Program Reimbursement has been issued to the provider, and then transfers cost report to inactive storage. Once the freeze is lifted, destroy the cost report files 5 years after receipt.

(Exception: A cost report file that is the subject of an appeal, litigation, or any other administrative proceedings, e.g., collection of outstanding overpayments or bankruptcies is not sent to inactive storage until the case has been settled or closed and all the review and appeal procedures have been exhausted.)

22. FI and Carrier Closing Agreements

These files contain the accepted final settlement for all FI and carrier costs of administration and consist of the closing agreement, appendix, and schedules of balances due the FI/carrier or Secretary.

Disposition: The FI or carrier cuts off files at the end of the fiscal year. It holds the file in office 1 year after HHS audit and final settlement then transfer to inactive storage. Destroy these 10 years after HHS audit and final settlement.

23. Medicare Data Match Files (FROZEN – DO NOT DESTROY)

Questionnaires, case files, employer records and data match records.

Disposition: Cutoff files at the end of the calendar month and transfer to an offsite storage facility. Once the freeze is lifted, destroy 6 years and 3 months after cutoff.

24. Initial Enrollment Questionnaire (FROZEN – DO NOT DESTROY)

Questionnaires sent to newly enrolled Medicare beneficiaries to obtain information on whether the individual is covered under a primary insurance plan.

Disposition: Once the freeze is lifted, destroy/delete when 5 years old.

25. Provider Statistical and Reimbursement Reports (PS&RR) – (FROZEN – DO NOT DESTROY)

These files consist of EDP printouts or microforms showing summaries of payments to hospitals, skilled nursing facilities, home health agencies, and other providers of service. They are used to effect cost settlements between the FIs and the providers for program validation purposes and to determine accuracy of cost reports. These reports contain Part A and Part B inpatient and outpatient information, inpatient statistics, total bills, covered costs, and other related data.

Disposition: Once the freeze is lifted, destroy 5 years after completion of audit and/or settlement process for provider cost report for corresponding fiscal year.

26. Carrier Claims Processing File

Consists of documents relating to Part B carrier performance. Submitted on a weekly basis electronically to CMS's data center.

Disposition: Destroy after 6 months.

30.40 - Retention of Claims File Materials

(Rev. 38, Issued: 05-26-06, Effective: 06-26-06, Implementation: 06-26-06)

After the claims determination payment action and posting to CMS records is completed, the bills and related materials are accumulated in file segments and held before transfer to an approved offsite storage facility (see §30.40.2). Claims records having current value and continuing reference, or claims records otherwise flagged to indicate pending action, are retained as long as the carrier finds necessary.

30.40.1 - Segment File Accumulation Period

(Rev. 38, Issued: 05-26-06, Effective: 06-26-06, Implementation: 06-26-06)

In order to facilitate the transfer of material to an approved offsite storage facility, intermediaries and carriers maintain the permanent claims records files in accumulation period segments, based on the starting date of initial payment or denial. Each contractor may select an accumulation period segment of from 6 months to 2 years in length after such starting date. The contractor may also adopt one period of time on an ongoing basis, but a different period for the initial segment.

Contractors who have been authorized to microfilm/image claims records may be authorized to shorten the segment file accumulation period. (See §30.50.)

After a file segment is closed, the contractor retains the records contained in that segment until time to transfer them to an approved storage facility. (See §§30.40.2 and 30.40.3 for definition of retention periods.)

EXCEPTION: Contractors who maintain total history files by individual claim number, name, or other sequence, may wish to operate under some procedure other than by a file segment accumulation period.

Such alternative procedures may be used provided purging techniques to withdraw inactive records are established which meet one of the following requirements:

1. They avoid costly and time consuming manual selection of material to be purged from each folder.
2. Separators are used for each year's (or other period's) material within the history folder to facilitate rapid selection.
3. The capability exists (e.g., computer prepared lists) to identify inactive cases in which no action has been taken for 12 months or more for selection as purged segments to be transferred to an approved storage facility when such a purge becomes necessary.
4. Periods for purging and transfer are carefully selected by studying rates of reference to claims materials in order to select a realistic inactive period to avoid unnecessary recall from the storage facility.

Although contractors who follow a purging procedure need not establish a standard retention period, the establishment of one of these requirements provides them with the potential of transferring inactive files to a storage facility if such a transfer should become desirable. When such a purge is begun, the contractor should make no transfer to the storage facility until the entire purging operation for the period is completed.

30.40.2 - Standard Retention Periods – Microfilmed Claims **(Rev. 38, Issued: 05-26-06, Effective: 06-26-06, Implementation: 06-26-06)**

Contractors keep each permanent claims records file segment for a period of not less than 6 months or more than 1 1/2 years after the segment has been closed. The contractor bases the selection of a retention period on its experience with the rate and frequency of reference and other criteria. It also should avoid too early transfer to the storage facility, which could result in volume recalls and delays. The contractor bases the exact length of the retention period on its needs and on the arrangements worked out with the storage facility.

The following examples of segment accumulation and retention periods demonstrate some of the ways in which these periods can vary.

EXAMPLES:

Segment File

Accumulation Period	Retention Period	Transfer
a. 6 months		
7/1/05 - 12/31/05	6 months	7/1/06
1/1/06 - 6/30/06	6 months	1/1/07
1/1/06 - 6/30/06	12 months	7/1/06
1/1/06 - 6/30/06	18 months	1/1/07
b. 9 months		
7/1/05 - 3/31/06	6 months	10/1/06
7/1/05 - 3/31/06	12 months	4/1/07
7/1/05 - 3/31/06	18 months	10/1/07
c. 12 months		
1/1/05 - 12/31/05	6 months	7/1/06
1/1/05 - 12/31/05	12 months	1/1/07
1/1/05 - 12/31/05	18 months	7/1/07
d. 18 months		
1/1/05 - 6/30/07	6 months	1/1/08
1/1/05 - 6/30/07	12 months	7/1/08
1/1/05 - 6/30/07	18 months	1/1/09
e. 2 years		
7/1/05 - 6/30/07	6 months	1/1/08
7/1/05 - 6/30/07	12 months	7/1/07

7/1/05 - 6/30/07

18 months

1/1/09

30.40.3 - Retention Period - Microfilmed Material

(Rev. 38, Issued: 05-26-06, Effective: 06-26-06, Implementation: 06-26-06)

Intermediaries and carriers who have been authorized to microfilm claims records (see §§50ff) may be permitted to transfer an accumulation of the original source documents to an approved offsite storage facility, after retaining for a shorter period than is outlined in §§30.30.40 – 30.30.40.2.

Accumulation Period	Retention Period	Transfer
a. 1/1/06 - 1/31/06	1 month	3/1/06
b. 6/1/06 - 6/30/06	1 month	8/1/06

30.50 - Microfilming of Files Material

(Rev. 38, Issued: 05-26-06, Effective: 06-26-06, Implementation: 06-26-06)

Some intermediaries and carriers have been authorized to microfilm claims records and other files material; e.g., computer printouts, cancelled checks, financial records. Due to the document freeze, these contractors are not authorized to destroy original source documents but are permitted to transfer an accumulation of these documents to an offsite storage facility after microfilming and verification of the quality and completeness of the film. (See §30.30.2, item 3, concerning destruction the hard copy Medicare Summary Notices after microfilming.) The accumulation period may be daily, weekly, or monthly, depending on volume. Generally, contractors should not make shipments of less than three cartons. They coordinate transfer procedures with the storage facility.

In §30.90, Exhibits 6-12 contain various sample forms to be used by contractors when microfilming files material. These forms are not supplied by CMS. Reproduction of the forms is the responsibility of the contractor.

30.50.1 - Microfilming Procedures

(Rev. 38, Issued: 05-26-06, Effective: 06-26-06, Implementation: 06-26-06)

A – General

The contractor must authenticate each roll of film containing reproductions of Medicare claims records by including certificates of authenticity at the start and at the end of the filmed documents. (Material other than claims records need not be authenticated.) The contractor produces these certificates and target cards as needed, using the language contained in the examples in §80, Exhibits 6-12. The camera operator completes a report for each roll that is microfilmed. See Exhibit 12, for an example of a roll report. The contractor films claims records without attachments (e.g., coding sheets) overlaying data on the record. If data on the attachment is needed for reference purpose, the contractor films it separately.

To ensure that the camera is working efficiently when files material is being microfilmed, the contractor films a microcopy resolution test chart on the first roll in the morning and the first roll in the afternoon. It gives these rolls priority processing so that any camera malfunction is discovered as soon as possible. Exhibit 11 provides an example of a resolution test chart that cannot be used for actual tests. Usable charts are available from microfilm suppliers.

B - Normal Filming

The contractor films the start certificate (see Exhibit 5) after any target (or flash) cards that identify or index the documents on the film and before the records are filmed. It films the end certificate (Exhibit 6) after the last document and before any end target card. It retains documents in the order they were filmed for ease in reviewing the processed microfilm.

The following is an example of normal filming sequence:

OUT START OF FILM	LEADER <ABOUT- 2 FEET	ROLL NUMBER CARD	TITLE CARD	FILING SEQUENCE CARD	START CERTIFICATION OF AUTHENTICITY CARD	TEST* CHART
----------------------------	-----------------------------	------------------------	---------------	----------------------------	--	----------------

\					LAST	\
/				LAST	CERTIFICATE	/
\	DOCUMENT	DOCUMENT	DOCUMENT	DOCUMENT	OF	\
/					AUTHENTICITY	/
\					CARD	\

/				*Filmed Twice Each Day	\
\	END	←	TRAILER ABOUT	END OF FILM	/
/	CARD		2 FEET	/	\
\					/
					\

C – Corrections

If the camera operator notices that a document has been incorrectly filmed due to being twisted, folded, or torn, photograph a correction card (see Exhibit 7) right after the incorrect document.

The following is an example of correction filming sequence:

\						
/	DOCUMENT	DOCUMENT	CORRECTION	DOCUMENT	DOCUMENT	/
\		(TORN)	CARD	(REPAIRED)		\
/						/
\						\

D - Filming Retakes and Additions

When the processed microfilm roll is reviewed, some documents may be illegible or incorrectly photographed. Other documents may have been out of file or omitted at the time of the original microfilming. The contractor will re-photograph these documents and splice onto the front of the completed microfilm roll. If splicing is not practical, it will maintain the retakes and additions as a separate microfilm roll. It will photograph a start of retake or addition card (Exhibit 8) immediately before the documents to be rephotographed or added. Photograph an end of retake or addition certificate (Exhibit 9) immediately after the last document to be rephotographed. The following is an example of retake or addition filming sequence:

\						\
/	START RE-TAKE OR	DOCUMENT	DOCUMENT	DOCUMENT	END OF	/
\	ADDITION				ADDITION OR	\
/	CARD				RETAKE	/
\					CERTIFICATE	\

30.50.2 - Microfilming Index Label

(Rev. 38, Issued: 05-26-06, Effective: 06-26-06, Implementation: 06-26-06)

Affix an index label to each contents of the roll microfilm and provide reference markers. It lists the normal filming and the retakes and additions.

Below is an example of an index label:

Title:	Roll No.
CMS-1453	
CONTENTS INDEX	
Index Point 1	
CMS-1453	Control Number
00400	Through 00450
Index Point 2	
CMS-1453	Control Number
00451	Through 00499
Index Point 3	
Retakes 00427, 00451, 00478	
Index Point 4	
Additions 00429, 00446, 00463	
END OF ROLL	
End of Roll	

30.50.3 - Retention and Destruction of Microfilm

(Rev. 38, Issued: 05-26-06, Effective: 06-26-06, Implementation: 06-26-06)

A - Master Microfilm

After producing the number of copies of the microfilm required for reference purposes, the contractor retains the master microfilm as a security file. It stores it at an offsite location so that copies may be made in the event the reference copies are destroyed. It disposes of the master microfilm at the time the storage facility disposes of the hardcopy contained on the film. (See §30.30 for records disposition instructions.)

(The contractor need not maintain a master microfilm security file of records such as computer printouts when complete computerized backup data is retained. It disposes of the master microfilm when there is no longer a need to produce reference copies of the microfilm.)

B - Copies of Microfilm

The contractor retains one copy of the microfilm as a reference copy to be kept on site for use when needed. It disposes of this copy with the master microfilm. (See subsection A above.)

The contractor may dispose of any other reference copies of the microfilm 2 years after the end of the calendar year in which the documents were filmed. These copies may be retained for a longer period if they are needed for reference purposes but not longer than the master microfilm.

C - Destruction of Microfilm

The contractor should destroy microfilm by shredding as this method provides the most complete destruction of the data on the film. Other methods of destroying film, e.g., exposure to extreme heat or boiling, do not eradicate the data as completely or efficiently. Shredders exist that can destroy both film and reels. The contractor should retain cartridges or magazines which contained the microfilm for reuse because of the high cost of replacement.

If a contractor does not have a shredder and purchase of a shredder is not cost justified, it should check local sources such as microfilm equipment vendors, microfilm service bureaus, banks, and insurance companies for a shredder that it can use to destroy its film. If a shredder cannot be located, the contractor should contact its regional office for assistance.

30.60 – Annual Report of Medicare Records

(Rev. 38, Issued: 05-26-06, Effective: 06-26-06, Implementation: 06-26-06)

The Centers for Medicare & Medicaid Services (CMS) conducts a reporting of total records on hand in current file rooms, offices, and offsite storage facilities. Since Medicare claims records and related records created and maintained by you must be included, you must prepare an Annual Report of Medicare Records (See Exhibit 13).

Each contractor shall prepare this report every year as of September 15, regardless of your fiscal year ending date, and mail one copy to reach the address shown below no later than September 30:

Centers for Medicare & Medicaid Services
Records Officer, OSORA/IRMG
Mail Stop, SL-12-16
7500 Security Boulevard
Baltimore, MD 21244-1850

30.70 - Disposition of Non-Claims Materials

(Rev. 38, Issued: 05-26-06, Effective: 06-26-06, Implementation: 06-26-06)

Non-claims materials, as defined in §30.10.1B, may be disposed of by the contractor. Retained CMS bill copies (where records were submitted on tape) may be destroyed.

In disposing of this material, the contractor must:

- Ensure the confidentiality of information regarding a particular beneficiary, provider, physician, or supplier by protective shredding, mutilation, or contractual provisions with the subcontractor regarding similar protective measures.

- Provide for offsetting expenditures with salvage value received when contractual relationships have been established with a local contractor for the sale of non-claims materials for its salvage value. In such cases, the contractor records the salvage value received, and offsets the initial expense of purchasing such materials by such value received.

30.80 – Standards for All Records Storage Facilities

(Rev. 38, Issued: 05-26-06, Effective: 06-26-06, Implementation: 06-26-06)

A facility that is used to store Federal records, must meet the minimum structural, environmental, property and life safety standards as outlined in 36 CFR 1228.228-Facility Requirements http://www.access.gpo.gov/nara/cfr/waisidx_05/36cfr1228_05.html by October 1, 2009. You must submit a Facility Standards for Record Storage Facilities Inspection Checklist (see Exhibit 14) for all storage facilities used to house CMS records to the CMS Records Officer.

The facility must be constructed with non-combustible materials and building elements, including walls, columns and floors. You may request a waiver of this requirement from the National Archives and Records Administration through CMS for an existing records facility with combustible building elements to continue to operate until October 1, 2009. Your request must provide documentation that the facility has a fire suppression system specifically designed to mitigate this hazard and that the system meets the requirements in 36 CFR 1228.230--Fire Safety Requirements http://www.access.gpo.gov/nara/cfr/waisidx_05/36cfr1228_05.html. Requests for waivers must be submitted to your CMS Regional Office contact who will forward to the CMS Records Officer for final approval by the National Archives and Records Administration.

30.90 - Exhibits

(Rev. 38, Issued: 05-26-06, Effective: 06-26-06, Implementation: 06-26-06)

- Exhibit 1. Preprinted Container Label
- Exhibit 2. Minimum Label Data Required for Unlabeled Boxes
- Exhibit 3. Records Transmittal and Receipt – Standard Form 135
- Exhibit 4. Reference Request – Federal Records Center – Optional Form 11
- Exhibit 5. Certificate of Authenticity - Start
- Exhibit 6. Certificate of Authenticity – End
- Exhibit 7. Correction Card
- Exhibit 8. Start of Retake or Addition Certificate
- Exhibit 9. Retake or Addition Certification
- Exhibit 10. Resolution Test Chart
- Exhibit 11. Witness Disposal Certification (Sample)

Exhibit 12. Roll Report

Exhibit 13 Report of Medicare Records

Exhibit 14 Inspection Checklist -- Standards for Record Storage Facilities

Exhibit 1 – Preprinted Container Label

(Rev. 38, Issued: 05-26-06, Effective: 06-26-06, Implementation: 06-26-06)

ACCESSION NO.	CARTON NO. of
AGENCY	MAJOR SUBDIVISION
DESCRIPTION OF RECORDS (BRIEF)	

Instructions for Completing Label

Accession No. – Control number you assign to each shipment of records.

Carton No. – Show the box number and also the total number of boxes in the same shipment, e.g., 5 of 60.

Agency – Enter CMS

Major Subdivision – Enter the name of the intermediary or carrier in this block.

Description of Records – Enter “Part A Intermediary or Part B Carrier – Medicare bills and related claims records received, processed and paid (including dates),” or “Part A Intermediary – Medicare Fiscal Records, canceled checks and related records (including dates).”

Also, for each box, show the inclusive claims numbers, dates, etc., depending on arrangement of records, e.g., “086-12-8462—093-14-2362”.

Exhibit 2 - Minimum Label Data Required for Unlabeled Boxes
(Rev. 38, Issued: 05-26-06, Effective: 06-26-06, Implementation: 06-26-06)

For boxes not having a preprinted label (see Exhibit 1 above), enter the label as shown:

CARTON _____ OF _____ CARTONS
CMS
INTERMEDIARY or CARRIER NAME
CITY, STATE
FISCAL INTERMEDIARY or CARRIER - PAID MEDICARE BILLS
DATE TO DATE
(086-12-8462A--093-14-2362T)

Instructions For Labeling Boxes

Use broad-point felt tip marker to facilitate shelf reference.

Minimum Label Data

Accession Number – Control number assigned to each shipment of records.

Carton No.--Show the box number and also total boxes in the shipment, e.g., 5 of 60.

Agency--Show "CMS."

Office--Show the name of Intermediary or Carrier with city and State address.

Description of Records--For Medicare bills and related records, show: "Fiscal Intermediary or Carrier name - Paid Medicare Bills (inclusive dates)." For fiscal records, canceled checks, and related records, show: "Fiscal Intermediary or Carrier - Medicare Fiscal Records (inclusive dates)."

First and Last Entry in Box--Show the inclusive claim number, terminal digit numbers, check numbers, or other designated key numbers (e.g., 086-12-8462A--093-14-2362T).

Exhibit 3 – Records Transmittal and Receipt – Standard Form 135
(Rev. 38, Issued: 05-26-06, Effective: 06-26-06, Implementation: 06-26-06)

Click on the link below then scroll down and click on “Records Transmittal and Receipt Form – SF135”.

http://www.archives.gov/records_center_program/forms/sf_135_intro.html

Exhibit 4 – Reference Request – Federal Records Center – Optional Form 11
(Rev. 38, Issued: 05-26-06, Effective: 06-26-06, Implementation: 06-26-06)

Click on the link below to access Optional Form 11

<http://www.gsa.gov/forms>

Exhibit 5 - Certificate of Authenticity – START
(Rev. 38, Issued: 05-26-06, Effective: 06-26-06, Implementation: 06-26-06)

CONTRACTOR NAME AND ADDRESS

CERTIFICATE OF AUTHENTICITY

START

THIS IS TO CERTIFY THAT THE MICROPHOTOGRAPHIC IMAGES APPEARING ON THIS ROLL OF MICROFILM:

STARTING WITH (e.g., control number, health insurance claim number)

ARE ACCURATE REPRODUCTIONS OF THE RECORDS OF:

AND WERE MICROFILMED IN THE REGULAR COURSE OF BUSINESS PURSUANT TO ESTABLISHED ROUTINE COMPANY POLICY FOR SYSTEMS UTILIZATION AND OR FOR THE MAINTENANCE AND PRESERVATION OF SUCH RECORDS THROUGH THE STORAGE OF SUCH MICROFILMS IN PROTECTED LOCATIONS.

IT IS FURTHER CERTIFIED THAT THE PHOTOGRAPHIC PROCESSES USED FOR MICROFILMING OF THE ABOVE RECORDS WERE ACCOMPLISHED IN A MANNER AND ON MICROFILM THAT MEETS THE RECOMMENDED REQUIREMENTS OF THE NATIONAL BUREAU OF STANDARDS FOR PERMANENT MICROPHOTOGRAPHIC REPRODUCTIONS.

Date Microfilmed

Camera Operator

Location

Authorized Signature

Exhibit 6 – Certificate of Authenticity – END

(Rev. 38, Issued: 05-26-06, Effective: 06-26-06, Implementation: 06-26-06)

CONTRACTOR NAME AND ADDRESS

CERTIFICATE OF AUTHENTICITY

END

THIS IS TO CERTIFY THAT THE MICROPHOTOGRAPHIC IMAGES APPEARING ON
THIS ROLL OF MICROFILM:

ENDING WITH

ARE ACCURATE REPRODUCTIONS OF THE RECORDS OF:

AND WERE MICROFILMED IN THE REGULAR COURSE OF BUSINESS PURSUANT TO
ESTABLISHED ROUTINE COMPANY POLICY FOR SYSTEMS UTILIZATION AND OR
FOR THE MAINTENANCE AND PRESERVATION OF SUCH RECORDS THROUGH THE
STORAGE OF SUCH MICROFILMS IN PROTECTED LOCATIONS.

IT IS FURTHER CERTIFIED THAT THE PHOTOGRAPHIC PROCESSES USED FOR
MICROFILMING OF THE ABOVE RECORDS WERE ACCOMPLISHED IN A MANNER
AND ON MICROFILM THAT MEETS THE RECOMMENDED REQUIREMENTS OF THE
NATIONAL BUREAU OF STANDARDS FOR PERMANENT MICROPHOTOGRAPHIC
REPRODUCTIONS.

Date Microfilmed

Camera Operator

Location

Authorized Signature

Exhibit 7 – Correction Card

(Rev. 38, Issued: 05-26-06, Effective: 06-26-06, Implementation: 06-26-06)

CORRECTION CARD
CORRECTION THIS DOCUMENT HAS BEEN REPHOTOGRAPHED TO ASSURE LEGIBILITY

Exhibit 8 – Start of Retake or Addition Certificate
(Rev. 38, Issued: 05-26-06, Effective: 06-26-06, Implementation: 06-26-06)

RETAKE OR ADDITION CARD
START OF RETAKE OR ADDITION The images appearing between this point and the "End of Retake or Addition" are true copies of records, which were missing or provide unsatisfactory on inspection of the original microfilm reel. For a description of rephotographed material, see operator's "Retake or Addition Certificate" at the end of this section.

Exhibit 9 – Retake or Addition Certificate
(Rev. 38, Issued: 05-26-06, Effective: 06-26-06, Implementation: 06-26-06)

CONTRACTOR NAME AND ADDRESS

CERTIFICATE OF AUTHENTICITY

RETAKES OR ADDITIONS

THIS IS TO CERTIFY THAT THE MICROPHOTOGRAPHIC IMAGES APPEARING ON
THIS ROLL OF MICROFILM:
ENDING WITH

ARE ACCURATE REPRODUCTIONS OF THE RECORDS OF:

AND WERE MICROFILMED IN THE REGULAR COURSE OF BUSINESS PURSUANT TO
ESTABLISHED ROUTINE COMPANY POLICY FOR SYSTEMS UTILIZATION AND OR
FOR THE MAINTENANCE AND PRESERVATION OF SUCH RECORDS THROUGH THE
STORAGE OF SUCH MICROFILMS IN PROTECTED LOCATIONS.

IT IS FURTHER CERTIFIED THAT THE PHOTOGRAPHIC PROCESSES USED FOR
MICROFILMING OF THE ABOVE RECORDS WERE ACCOMPLISHED IN A MANNER
AND ON MICROFILM THAT MEETS THE RECOMMENDED REQUIREMENTS OF THE
NATIONAL BUREAU OF STANDARDS FOR PERMANENT MICROPHOTOGRAPHIC
REPRODUCTIONS.

Date Microfilmed

Camera Operator

Location

Authorized Signature

Exhibit 10 – Resolution Test Chart

(Rev. 38, Issued: 05-26-06, Effective: 06-26-06, Implementation: 06-26-06)

The resolution test chart can also be viewed at the following link:

<http://www.efg2.com/Lab/ImageProcessing/TestTargets/#Microcopy>

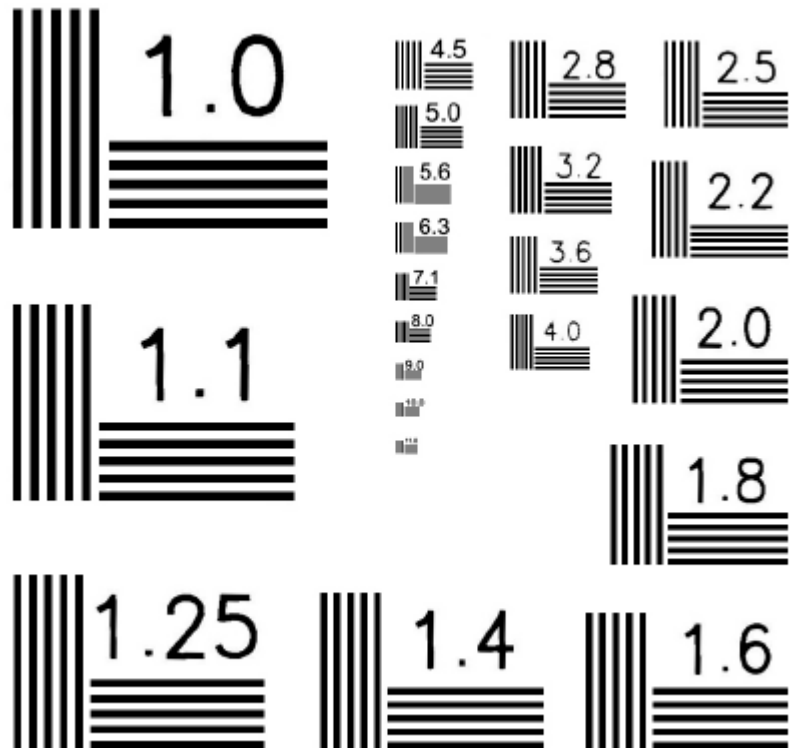


Exhibit 11 – Witness Disposal Certification (Sample)

(Rev. 38, Issued: 05-26-06, Effective: 06-26-06, Implementation: 06-26-06)

WITNESSED DISPOSAL CERTIFICATION

Disposal Date: _____

Medicare Contractor: _____

Address: _____

Disposal Location: _____

Volume by Cubic Feet (e.g., number of boxes): _____

Description & Year(s) of Records Destroyed:

I certify that I witnessed the proper destruction of CMS Medicare records approved for disposal on the date and location named in this document.

Print Name: _____

Title: _____

Signature: _____

Date: _____

Exhibit 12 – Roll Report

(Rev. 38, Issued: 05-26-06, Effective: 06-26-06, Implementation: 06-26-06)

ROLL REPORT

AGENCY	THEIR ROLL
NAME	NO.
	OUR ORDER
	NUMBER

CAMERA NO.	LIGHT LEVEL	IRIS	REDUCTION
------------	-------------	------	-----------

	FILMING
	TIME

LUNCH	BREAK	PREP	WAITING	SET-UP	TRAVEL
TIME	TIME	TIME	TIME	TIME	TIME

PROCESSING DEPARTMENT

DATE	DEV.	CHEM.	REMARKS	PROCESSOR
PROC.	TIME	TEMP		

INSPECTION DEPARTMENT

APPROVED		INSPEC.	INSPECTORS	
RESHOOTS	FOOTAGE	TIME	INITIALS	DENSITY

RESHOOTS WILL BE FOUND ON

THIS ROLL FOR ROLL NUMBERS

REMARKS

OPERATOR'S INITIALS

Exhibit 13 – Report of Medicare Records**(Rev. 38, Issued: 05-26-06, Effective: 06-26-06, Implementation: 06-26-06)**

ANNUAL REPORT OF MEDICARE RECORDS			
Name & Address of Medicare Contractor			
Name, Title and Phone # of the Person Submitting the Report			
Type of Medicare Contractor (Carrier/Intermediary/DMERC, etc.)			
	Current File Room	Offsite Storage	Storage Costs
1. Total Records on Hand at the End of the Reporting Period			
a. Magnetic Tape Included in Line 1			
b. Microfilm Included in Line 1			
c. CDs included in Line 1			
d. Paper included in Line 1			
2. Records Transferred to Storage During Reporting Period (provide the number of boxes)			

a. To Offsite Storage Included in Line 2			\$
b. To Onsite Storage Included in Line 2			\$
TOTAL STORAGE COSTS (Add 2a+b)			\$
3. Total Records in Offsite Storage During the Contract Period			

For the purpose of this report, volume may be calculated according to the following table of cubic foot equivalents:

1 record storage box.....1 cubic foot
Letter-size filing cabinet.....1½ cubic feet per drawer
Legal-size filing cabinet.....2 cubic feet per drawer
Magnetic Tape.....1 cubic foot per 7 reels
Microfilm.....1 cubic foot per 108 rolls
CDs.....¼ cubic foot per 12” case holder

Exhibit 14 – Inspection Checklist – Facility Standards for Records Storage Facilities

(Rev. 38, Issued: 05-26-06, Effective: 06-26-06, Implementation: 06-26-06)

Facility Standards for Records Storage Facilities		
Inspection Checklist		
(Effective date of checklist September 2005)		
Agency:		
Facility:	Common Name:	
	Street Address	
	City, State & Zip	
Facility	<<Typed name>>	
Director or	<<Typed Title>>	
Representative:	<input type="checkbox"/> Comments explaining or disagreeing with inspection findings are attached.	
Inspector:	<div><div></div><div><<Typed name>></div><div><<Typed Title>></div></div> <div><div></div><div>Date</div></div>	
Facility Description:		

Compliance with 36 CFR 1228.228 Facility Requirements				
§1228.228 paragraph:	Requirement	OK	No	Other
(a)	The facility must be constructed with non-combustible materials and building elements, including walls, columns, and floors.			
(a) exception 1	If the roof is constructed of combustible material it is protected by a properly installed and maintained wet-pipe automatic sprinkler system.			
(a) exception 2	Existing records storage facility with combustible building elements has an approved waiver from NAS that allows continued use until October 1, 2009 provided documentation has been submitted that indicates a fire-suppression system designed to mitigate the risk is present.			
(b)	A facility with two or more stories must be designed or certified by a licensed fire protection engineer and civil/structural engineer to avoid catastrophic failure of the structure due to an uncontrolled fire on one of the intermediate levels.			
(c)	The building must be sited a minimum of five feet above and 100 feet from any 100 year flood plain areas, or be protected by an appropriate flood wall (see FEMA flood maps)			
(d)	The facility must be designed in accordance with national, regional, state or local building codes (whichever is most stringent) to provide protection from building collapse or failure of essential equipment from earthquake hazards, tornadoes, hurricanes, and other natural disasters.			
(e)	Roads, fire lanes, and parking areas must permit unrestricted access for emergency vehicles.			
(f)	A floor load limit must be established for the records storage area by a licensed structural engineer. ... The allowable load limit must be posted in a conspicuous place and must not be exceeded.			
(g)	The facility must ensure that the roof membrane does not permit water to penetrate the roof. (New buildings: effective 9/28/2005; existing buildings: effective 10/1/2009)			

(h)	Piping (with the exception of sprinkler piping and storm water roof drainage piping) must not be run through the records storage area unless supplemental measures ... are used to prevent water leaks (New buildings: effective 9/28/2005; existing buildings: effective 10/1/2009)			
(i)(1)	All storage shelving must be designed and installed to provide seismic bracing that meets the requirements of the applicable state, regional, and local building code (whichever is most stringent).			
(i)(2)	Racking systems, steel shelving, or other open-shelf records storage equipment must be braced to prevent collapse under full load. Each shelving unit must be industrial style shelving rated at least 50 lbs per cubic foot supported by the shelf.			
(i)(3)	Compact shelving, if used, must be designed to permit proper air circulation and fire protection ...			
(j)	The records storage area must be equipped with an anti-intrusion alarm system ... meeting the requirements of UL 1076, Proprietary Burglar Alarm Units and Systems (level AA) The alarm system must be monitored in accordance with UL 611, Central Station Burglar Alarm Systems.			
(k)	The facility must comply with the requirements for a Level III facility. (Appendix A -- see separate checklist)			
(l)	Records contaminated by hazardous materials ... must be stored in separate areas having separate air handling systems from other records.			
(m)	The facility must have an Integrated Pest Management program.			

(n)	The following additional requirements apply only to new facilities:			
(n.1)	(1) No mechanical equipment containing motors in excess of 1 HP within records storage areas (excluding material handling and conveyance equipment that have operating thermal breakers on the motor).			
(n.2)	(2) No high-voltage electrical distribution equipment (i.e., 13.2kv or higher) in records storage areas.			
(n.3)	(3) A redundant source of primary electrical service ... should be provided Manual switching between sources of service is acceptable. (See text in rule; applies to HVAC, fire and security alarms.)			
(n.4)	(4) For new facilities that store permanent records:			
a.	a. A facility storing permanent records must be kept under positive pressure.			
b.	b. No intake louvers in loading dock areas, parking or other areas subject to vehicle traffic.			
c.	c. Separate air supply and exhaust system for loading docks.			

Compliance with 36 CFR 1228.230 Fire Safety Requirements				
§1228.230 paragraph:	Requirement	OK	No	Other
(a)	The fire detection and protection system must be designed or reviewed by a licensed fire protection engineer. Review requires submission of a report under the seal of a licensed fire protection engineer; see rule text for minimum requirements.			
(b)(1)	All walls separating records storage areas from each other and from storage areas within the building must be 3-hour fire resistant.			

Compliance with 36 CFR 1228.230 Fire Safety Requirements				
§1228.230 paragraph:	Requirement	OK	No	Other
(b)(2)	The quantity of Federal records stored in a single fire compartment shall not exceed 250,000 cubic feet.			
(c)(1)	For existing records storage facilities, at least 1-hour rated fire barrier walls must be provided between the records storage area(s) and other auxiliary spaces.			
(c)(2)(a)	For new records storage facility, 2-hour-rated fire barrier walls must be provided between the records storage area(s) and other auxiliary spaces.			
(c)(2)(b)	For new facilities, at least one exterior wall of each stack area must be designed with a maximum fire resistive rating of one-hour, or, if rated more than one-hour, there must be at least one knock-out panel in one exterior wall of each stack.			
(d)	Penetrations in the walls must not reduce the specified fire resistance ratings.			
(e)	The fire resistive rating of the roof must be a minimum of ½ hour.			
(e) alternate	Unrated roof is protected in accordance with NFPA 13.			
(f)	Openings in fire barrier walls must be protected by self-closing or automatic Class A fire doors, or equivalent doors that maintain the same rating as the wall.			
(g)	Roof support structures that cross or penetrate fire barrier walls must be cut and independently supported on each side of the fire barrier wall.			
(h)	If fire barrier walls are erected with expansion joints, the joints must be protected to their full height.			
(i)	Building columns in records storage areas must be 1-hour fire resistant.			
(i) alternate	Unrated columns are protected in accordance with NFPA 13.			

Compliance with 36 CFR 1228.230 Fire Safety Requirements				
§1228.230 paragraph:	Requirement	OK	No	Other
(j)(1)	Automatic roof vents for routine ventilation purposes must not be designed into new records storage facilities.			
(j)(2)	Automatic roof vents, designed solely to vent in the case of a fire, with a temperature rating of at least twice that of the sprinkler heads are acceptable.			
(k)	Where lightweight steel roof or floor supporting members are present, they must be protected either by applying a 10-minute fire resistive coating to the top chords of the joists, or by retrofitting the sprinkler system with large drop sprinkler heads. (see rule text)			
(l)	Open flame (oil or gas) unit heaters or equipment, if used, must be installed or used in any records storage area in accordance with NFPA 54 and the UMC.			
(m)	For existing records storage facilities, boiler rooms or rooms containing equipment operating with a fuel supply ... must be separated from records storage areas by a 2-hour rated fire barrier wall with no openings directly from those rooms to the records storage area(s). Such areas must be vented directly outside to a location where fumes will not be drawn back into the facility.			
(n)	For new records storage facilities, boiler rooms or rooms containing equipment operating with a fuel supply ... must be separated from records storage areas by a 4-hour rated fire barrier wall with no openings directly from those rooms to the records storage area(s). Such areas must be vented directly outside to a location where fumes will not be drawn back into the facility.			
(o)	For new records storage facilities, fuel supply lines must not be installed in areas containing records, and must be separated from such areas with 4-hour-rated construction.			
(p)	Equipment rows running perpendicular to the wall must comply with NFPA 101 Life Safety Code, with respect to egress requirements.			

Compliance with 36 CFR 1228.230 Fire Safety Requirements				
§1228.230 paragraph:	Requirement	OK	No	Other
(q)(1)	No oil-type transformers, except thermally protected devices included in light ballasts, may be installed in records storage areas.			
(q)(2)	All electrical wiring must be in metal conduit, except that armored cable may be used where flexible wiring connections to light fixtures are required			
(q)(3)	Battery charging areas for electric forklifts must be separated from records storage areas with at least a 2-hour rated fire barrier wall.			
(r)	Hazardous materials ... must not be stored in records storage areas.			
(s)	<p>All records storage and adjoining areas must be protected by a professionally designed fire-safety detection and suppression system that is designed to limit the maximum anticipated loss from any single fire event to a maximum of 300 cubic feet of records destroyed.</p> <p>For systems in accordance with App. B, attach checklist. For other designs, see § 1228.242 for documentation requirements.</p>			

Compliance with 36 CFR 1228.232, Environmental Control Requirements				
§1228.232 Paragraph:	Requirement	OK	No	Other
(a)	Paper-based temporary records must be stored under environmental conditions that prevent the active growth of mold. (See rule text)			
(b)	Nontextual temporary records, including microforms and audiovisual and electronic records, must be stored in records storage space that will ensure their preservation for their full retention period. Effective 9/28/2005 for new records storage facility and 10/1/2009 for existing facilities. (See rule text)			

[illegible]

Notes	
Reference (§ and ¶)	Comments

<p align="center">Facility Standards for Records Storage Facilities</p> <p align="center">Supplemental Check Lists: Appendix A and Appendix B</p>

Compliance with Federal Facility Security Standards, Level III (36 CFR Part 1228 Appendix A) (Complete for ALL facilities)				
Citation	Requirement	OK	No	Part
S1	Control of facility parking			

Compliance with Federal Facility Security Standards, Level III

(36 CFR Part 1228 Appendix A)

(Complete for ALL facilities)

Citation	Requirement	OK	No	Part
S2	Receiving/shipping procedures			
S3	Intrusion detection system with central monitoring			
S4	Meets Life Safety Standards			
S5	Adequate exits from records storage areas			
S6	High security locks on entrances/exits			
S7	Visitor control/screening system			
S8	Prevent unauthorized access to utility areas			
S9	Provide emergency power to critical systems			
S10	Conduct background security checks and/or establish security control procedures for service contract personnel			

Compliance with 36 CFR Part 1228 Appendix B

(Complete this section ONLY if the facility claims to be using the system described in Appendix B)

Paragraph	Requirement	OK	No	Part
2a.	The records storage height must not exceed the nominal 15 feet (+/-3 inches) records storage height.			
2b.	All records storage and adjoining areas must be protected by automatic wet pipe sprinklers.			
2c.	1. The sprinkler system must be rated at no higher than 285 degrees Fahrenheit utilizing quick response (QR) fire sprinkler heads.			

Compliance with 36 CFR Part 1228 Appendix B

(Complete this section ONLY if the facility claims to be using the system described in Appendix B)

Paragraph	Requirement	OK	No	Part
	2. The sprinkler system must be designed by a licensed fire protection engineer to provide the specified density for the most remote 1,500 square feet of floor area at the most remote sprinkler head in accordance with NFPA 13 (1996), Standard for the Installation of Sprinkler Systems.			
	3. Installation of the sprinkler system must be in accordance with NFPA 13 (1996), Standard for the Installation of Sprinkler Systems.			
	4. Contractor's Material and Test Certificates per NFPA 13 chapter 8.			
	5. Hydraulic Calculations.			
2d.	1. Maximum spacing of the sprinkler heads must be on a 10-foot grid.			
	2. The positioning of the heads must provide complete, unobstructed coverage, with a clearance of not less than 18 inches, but not more than 60 inches, from the top of the highest stored materials.			
2e.	The sprinkler system must be equipped with a water-flow alarm connected to a continuously staffed fire department or central station, with responsibility for immediate response.			
2f.	1. A manual fire alarm system must be provided with central station services or other automatic means of notifying the municipal fire department.			
	2. A manual alarm pull station must be located adjacent to each exit.			
2g.	All water cutoff valves in the sprinkler system must be equipped with automatic closure alarm connected to a continuously staffed station, with responsibility for immediate response.			
2h.	A dependable water supply free of interruption must be provided. This normally requires a backup supply			

Compliance with 36 CFR Part 1228 Appendix B

(Complete this section ONLY if the facility claims to be using the system described in Appendix B)

Paragraph	Requirement	OK	No	Part
	system having sufficient pressure and capacity to meet both fire hose and sprinkler requirements for 2 hours.			
2i.	Interior stand-pipe stations equipped with 1 ½ inch diameter hose may be provided in the records storage areas if required by the local fire department, enabling any point in the records storage area to be reached by a 50-foot hose stream from a 100-foot hose lay. If hose is provided, the cabinets must be marked "For Fire Department Use Only."			
2j.	Where fire hose cabinets are not required, stand-pipes must be provided at each floor landing in the building core or stair shaft. Hose outlets must have easily removable adapter and cap. Threads and valves must be compatible with the local fire department's equipment. Spacing must be so that any point in the records storage area can be reached with a 50-foot hose stream from a 100-foot hose lay.			
2k.	In addition to the designated sprinkler flow demand, 500 gpm must be provided for hose stream demand. The hose stream demand must be calculated into the system at the base of the main sprinkler riser.			
2l.	1. Fire hydrants must be located within 250 feet of each exterior entrance or other access to the records center that could be used by fire-fighters.			
	2. All hydrants must be at least 50 feet away from the building walls and adjacent to a roadway usable by fire apparatus. Fire hydrants must have at least two 2-½ inch hose outlets and a pumper connection. All threads must be compatible with local standards.			
2m.	Portable water-type fire extinguishers (2½ gallon stored-pressure type) must be provided at each fire alarm striking station (see also NFPA 10).			

Compliance with 36 CFR Part 1228 Appendix B

(Complete this section ONLY if the facility claims to be using the system described in Appendix B)

Compliance with 36 CFR Part 1228 Appendix B
(Complete this section ONLY if the facility claims to be using the system described in Appendix B)

Paragraph	Requirement	OK	No	Part
2n.	1. Where provided, the walking surface of the catwalks must be of expanded metal at least 0.09-inch thickness with a 2-inch mesh length. The surface opening ratio must be equal or greater than 0.75.			
	2. The sprinkler water demand for protection over bays with catwalks where records are not oriented perpendicular to the aisles must be calculated to give 0.3 gpm per square foot for the most remote 2,000 square feet.			

[illegible]

40 – Shared System Maintainer and Medicare Contractor Responsibilities for System Releases
(Rev. 6, 05-28-04)
A3-3600ff., A3-3800ff., B3-4000ff., B3-6000ff., (COB SOW - §4.8)

40.1 – Standardized Terminology for Claims Processing Systems
(Rev. 16, Issued: 01-28-05, Effective: 01-01-05 for Intermediaries and 04-04-05 for Carriers; Implementation: 04-04-05)

This is a responsibility for both FIs and carriers. Medicare requires implementation of a limited number of shared systems by all FIs and carriers for their claims process and related functions. This eliminates the need for each contractor to repeat development of the basic system.

The shared system maintainers, the carriers and the FIs shall use a standardized terminology to refer to common systems maintenance elements in all discussions, reporting, and documentation. A chart of topics, showing how each system currently refers to them, and what they are called is located at 40.1.2. The list is not exhaustive and both CMS and the maintainers shall add to it, deciding with each addition, the common term we shall use to describe it. Carriers and FIs have a stake in this standardization, since many access the Information Management (INFOMAN) databases each system maintainer populates to determine the status of changes of interest to them. Carriers and FIs also participate in discussions with each other, the maintainers, the various testing sites and with CMS, and using a common terminology will minimize confusion and misunderstanding.

The FIs and carriers shall examine their use of the system status information issued by the Shared System Maintainers to determine if they have internal applications that need to be adjusted to adopt the standardized terminology. If they have internal systems or processes that must be modified to reflect the standardization required by this instruction, they shall make those changes to coincide with the shared system changes.

40.1.1 - Standard Terminology Chart
(Rev. 16, Issued: 01-28-05, Effective: 01-01-05 for Intermediaries and 04-04-05 for Carriers; Implementation: 04-04-05)

STANDARD TERM	DESCRIPTION	FISS	MCS	VMS	CWF
QUESTION	Request for assistance and/or reported potential system problem	TAR "telephone assistance request"	PCN – telephone assistance request	PROB/CSR	PLOG "problem log"
PROBLEM	Confirmed system and/or documentation problems	PAR "project assistance request"	PLOG	PROB	PLOG

STANDARD TERM	DESCRIPTION	FISS	MCS	VMS	CWF
CR	Change Request - Any software modification made to the system as a result of a CMS mandate, user or maintainer initiated action	PAR	CR	CR/CMR	CR "change request" or PLOG depending on CMS direction.
CMS Status	CMS needs take action by answering a question, finalizing an instruction, etc.	CMS REVCMS MANDATE	CMS	ENT Entered	MCCB or CMS
CONF Status	PROBLEM, CR or proposed action is under discussion in a functional workgroup	CONF			
NSC Status (non-system change)	CMS CR does not require shared system change. May require FI or carrier maintenance			NSC in SLC	
RESEARCH Status	The system maintainer completes high level review of required changes by analyzing them and determining the intent of the change request	Research	PREQ	INP In process	ANLZ (analysis)
REQS Status	The system maintainer finalizes the business requirements	TAR - Referred PAR - REVIEW	REQS	INP In process	REQS (requirements)
WALKTHROUGH Status	The system maintainer presents the systems solution to the CR in a structured walkthrough discussion with CMS and Beta testers			CWT	

STANDARD TERM	DESCRIPTION	FISS	MCS	VMS	CWF
WORK Status	The system maintainer completes technical design, coding and unit testing the system change	PAR - WORK	WORK	DCG Design Control Group Technical Approval	PROG (programming and unit testing)
ALPHA Testing	Maintainer System Testing	PAR - TEST	QUAL	REL Release Ready	TEST (Alpha testing)
BETA Testing	Testing (Beta)	PAR - BETA	RLSE	REL Release Ready	BETA
UAT	User Acceptance Testing	PAR - RELEASE	LOAD	REL Release Ready	BETA (is for BETA and HOST testing)
USER Status	Back to user to provide more information or examples, assess solution	TAR - CUST PAR - N/A	Status I (PLOGs)	INP OR "W"	BETA (is for BETA and HOST testing)
SCHED Status	Scheduled to go out with a release date assigned for implementation	SCHED	PROD	REL Release Ready	NDM
RESOLVED	PROBLEM has been resolved: question answered, potential system anomaly explained or correction identified and scheduled for release			CLOSED	
RELEASE	Quarterly Release	Release	Quarterly release	Release	Quarterly Release
FOLLOW-UP	What Maintainers send out to augment a release or correct PROBLEMS directly			Post-Release Resync	

STANDARD TERM	DESCRIPTION	FISS	MCS	VMS	CWF
	related to a newly-installed release				
EMER Release	What Maintainers send out to fix Priority 1, 2, and urgent PROBLEMS	Release	Emergency release	Emergency Elevate	Priority or Emergency NDM 'network data mover' old name for Connect:Direct
OFF-QTR RELEASE	What Maintainers send out to fix non-urgent PROBLEMS between releases or to prepare for an upcoming release (e.g. update provider profile data)	Release	Priority release	Weekly / Off-Release Elevate	Special release NDM
Test Case	A description of an input situation and of the expected results associated with a specific test objective. (a Test Case may optionally include test steps provide to additional granularity)	Test Script	Test Script	Test Case	Test Case
Test Set	A group of test cases with a common goal (e.g., a test set to validate a specific CR, a regression test set)		Test Packet	Test Plan	

40.2 – Release Software

(Rev. 5, 05-07-04)

CMS intends to continue to closely manage standard system software changes to assure that an effective change control process is in place. This means that maintainers must receive approval

from their CMS system maintenance lead (see section VI) or CMS project officer before any follow-up release by the standard maintainer can be scheduled and installed.

Control of System Changes

All maintainers of the standard systems (CWF, FISS, APASS, MCS, VMS, GTEMS, and HPBSS systems) must use the same quarterly release schedule, i.e., on or about January 1, April 1, July 1, and October 1. The specific schedule for each quarterly release will be determined by CMS.

All follow-up release changes (except emergencies) to the quarterly schedule must be held and released on a predetermined schedule in coordination with CMS. Emergency changes may be released as problems are identified without prior approval. The schedule for follow-up release of changes must be forwarded to your CMS system maintenance lead or CMS project officer for prior approval.

Follow-up release changes are to be limited to the correction of priority 1 and 2 problems and errors that prevent effective operation of the production system. Priority 3, priority 4 and/or priority 5 problems may be corrected in a follow-up release when pre-approved by CMS. The CMS maintenance lead will advise you of the approval decision within 24 – 48 hours.

If a system problem is identified, Medicare organizations must submit documentation to their CMS system maintenance lead outlining the problem and the reason correction is needed at this time. Section V of this instruction outlines the minimum information required by CMS for approval.

Problem Priority Classifications for Follow-Up Releases

Listed below are CMS's problem priority classifications and examples. These are similar to the problem priority classifications that were used for the Y2K re-certification testing period.

Priority 1 Classification

Production:

The problem prevents the accomplishment of a mission critical capability for which no acceptable workaround is known.*

This priority also includes problems where code must be fixed immediately in order for the normal production region functions or services to continue. For example, if the production region is down in a job resulting in an incomplete cycle or the system is pricing a significant volume of claims incorrectly causing over or under payment. The maintainer may make priority 1 changes on its own authority. These corrections must be reported to the CMS maintenance lead or to the project officer the next business day.

EXAMPLES:

- ABENDS on-line or batch (Inability to run a cycle)
- Inaccurate payment or no payment of claims (significant impact/high volume)

- Necessary file updates cannot be accomplished (payment files, history files)
- Interface failures affecting claims processing

Beta/User Acceptance Testing:

The problem would prevent the accomplishment of a mission critical capability if the current test software is moved into the production environment. This priority also includes problems where code must be fixed immediately in order for the normal test region functions or services to continue. For example, if the test region is down in a job causing the cycle to not complete or the system is pricing claims incorrectly with a potentially significant claim volume or payment impact, the issue would be classified as a priority 1. The maintainer must work immediately to code a fix to be installed before moving the software into production.

EXAMPLES:

- ABENDS; inability to run a cycle or test
- Inaccurate payment or no payment of claims (potentially significant impact)
- Necessary file updates cannot be accomplished (payment files, history files)
- Interface failures affecting test conditions

Priority 2 Classification

Production:

The problem adversely affects the accomplishment of a mission critical capability so as to degrade performance and for which no acceptable work-around is known.* This means the problem adversely affects the payment of benefits with a small claim volume or payment impact, the completion of CMS required reporting, or inaccurate information is being sent providers, beneficiaries or CMS. For example, if the information on an outgoing document to the provider community or Medicare Summary Notice is incorrect, the issue would be classified as a priority 2. The system maintainer must work with the CMS maintenance lead for approval to implement a fix.

EXAMPLES:

- Inaccurate payment or no payment of claims (small impact/low volume)
- Inaccurate CMS required report
- Inaccurate messages to the beneficiary, provider or CMS
- ABENDs with limited impact (ex. One contractor)

Beta/User Acceptance Testing:

The problem would adversely affect the accomplishment of a mission critical capability so as to degrade performance if current test software is moved into the production environment. This means the problem adversely affects the payment of benefits with a potentially small claim volume or payment impact, the completion of CMS required reporting, or inaccurate information is being sent to providers, beneficiaries or CMS. For example, if the information on an outgoing document to the provider community is

incorrect, the issue would be classified as a priority 2. The maintainer must work immediately to code a fix to be installed before moving the software into production.

EXAMPLES:

- Inaccurate payment or no payment of claims (potentially small impact)
- Inaccurate CMS required report
- Inaccurate messages to the beneficiary, provider or CMS

Priority 3 Classification

Production:

The problem adversely affects the accomplishment of mission critical capability so as to degrade performance and for which an acceptable workaround is known.*

This means the problem could have significant impact but the work-around alleviates the impact. This allows the system maintainer adequate time to code a fix and sufficiently test before the corrected software is delivered for production installation. The system maintainer must work with the CMS maintenance lead to implement a fix.

EXAMPLES:

- Impact of problem could be significant or minimal
- Problem correctable by contractor workaround*
- ABENDs with an acceptable workaround*

Beta/User Acceptance Testing:

The problem would adversely impact the accomplishment of a mission critical capability so as to degrade performance if current test software is moved into the production environment.

If moved into the production environment before correcting an acceptable workaround could be instituted to prevent the adverse impact.** The system maintainer must work immediately to code a fix to be installed before moving the software into production.

EXAMPLES:

- Potential impact of problem could be significant or minimal
- Problem affects CMS required reporting

Priority 4 Classification

Production:

The problem is an operator inconvenience or annoyance, which does not affect a required mission essential capability. The system maintainer must request approval to code and implement a fix from its CMS maintenance lead.

EXAMPLES:

- Problems affects non-mission critical functions
- Operational procedure with workload impact that should be automated
- Impact of problem is minimal
- Correctable by contractor workaround*

Beta/User Acceptance Testing:

The problem is a test inconvenience or annoyance, which does not affect a required mission essential or test capability. If moved into the production environment before correcting, an acceptable workaround could be instituted to prevent the inconvenience.** The system maintainer should work immediately to code a fix to be installed before moving the software into production.

EXAMPLES:

- Problem affects non-mission critical functions
- Operational procedure with workload impact that should be automated
- Impact of problem is minimal
- Correctable by contractor workaround*

Priority 5 Classification

Production:

All other documented system problems. These could include operator errors, an inability to reproduce the reported problem, a problem with insufficient information, or documentation errors. The system maintainer should request approval from the CMS maintenance lead before coding and implementing any system enhancements.

EXAMPLES:

- Contractor requested enhancements
- Documentation errors (i.e. Business requirements)
- Problem affects non-mission critical functions
- Minimal impact

Beta/User Acceptance Testing:

All other documented system test problems. These could include operator errors, an inability to reproduce the reported problem, a problem with insufficient information, or test documentation errors. The system maintainer should work to correct these issues as soon as possible but any system enhancements should be discussed with the CMS maintenance lead.

Examples:

- Test region or processing enhancements
- Test documentation errors (i.e. business requirements)
- Problem affects non-mission critical test functions
- Minimal impact

* An acceptable workaround is a temporary alternative solution to a confirmed problem in the shared system that will insure the contractor is able to accomplish a mission critical capability. What makes the workaround “acceptable” is it must be agreeable to both the maintainer and contractor and does not cause an excessive burden to the contractor. If the maintainer and contractor cannot come to an agreement on what is “acceptable” the decision will be made by CMS.

** CMS does not recommend using workarounds in the test region in order to “pass” test cases. The institution of a workaround should be used in order to implement a CMS mandate where the system maintainer may not have time to adequately code a fix before the software is delivered for production installation.

Routine File Maintenance/Updates

CMS does not require pre-approval or special documentation of routine file maintenance/updates or other routine activities necessary for effective operation of the Medicare system, Medicare processes and/or testing (e.g., MR/UR screen updates, provider and beneficiary file updates). All contractors and data centers should continue with their normal file maintenance routines.

Testing Prior to Installation of CMS Approved Follow-up Releases

CMS explains expectation for each Medicare organization’s testing responsibility (i.e., standard system maintainer testing, contractor testing, CWF host testing, Beta testing).

Information Required for Requesting CMS Approval

The following must be submitted to the CMS maintenance lead or project officer when requesting that a problem be implemented in a follow-up release. If the system maintainer already has a process in place for communicating system problems to CMS, that process may be used as long as all information below, at a minimum, is captured.

MAINTAINER NAME:

Problem Description:

Brief non-technical business description of the fix.

How Found:

Explain how the problem was found. Also explain why you believe it was not found by release testing.

Problem Impact:

This information is needed to determine the scope of the problem in terms of payments, provider types, beneficiaries, number of potential claims impacted, if a work around is available, etc.

Problem Priority Classification:

Is this problem prioritized as an emergency, 1, 2, 3, 4, or 5.

Release Options:

Explain the options for scheduling and implementing the fix.

Technical Recommendation for Release timing:

Explain the recommended timing for installing the release.

CMS System Maintenance Leads

Maintainers must forward schedules and documentation of all changes as required in the memorandum to your CMS maintenance lead as indicated below. If your current process is to forward this information to your project officer, continue to do so. Your CMS maintenance leads will advise you of backup staff.

40.2.1 - Implementing Validated Workarounds for Shared System Claims Processing by All Medicare Contractors

(Rev. 57, Issued: 02-20-09, Effective: 01-01-09, Implementation: 03-20-09)

Medicare contractors shall implement workarounds within the shared systems for problems when formally defined as a Priority 3 or Priority 4 without obtaining written permission from a Project Officer or Regional Office.

Shared system problems that are formally defined as a Priority 3 or a Priority 4 have acceptable workarounds which provide temporarily alternative solutions. In order for a Medicare contractor to implement a workaround, the shared system maintainer must first validate the problem, confirm that the workaround exists, is systematically viable and does not cause adverse affects. The implementation of such workarounds will eliminate delay in adjudication of Medicare claims and the payment to providers. Utilizing a Priority 3 or Priority 4 workaround shall not diminish the integrity of the shared systems and shall not include such actions as deactivating standard edits. The shared system's priorities are formally defined at Section 40.2 of this chapter.

40.3 - Standard System Testing Requirements for Maintainers, Beta Testers, and Contractors

(Rev. 46, Issued: 07-20-07; Effective: 01-01-08; Implementation: 01-07-08)

Medicare requires implementation of a limited number of standard systems that must be used by all FIs and carriers. This eliminates the need for each Medicare Contractor to repeat development of the basic system.

CMS requires that the standard system quarterly release be subjected to the complete testing life cycle prior to production release. The goal is to ensure that all changes function as intended and that the implementation of changes does not degrade or otherwise unintentionally affect existing system capability and function prior to implementation. This requires that the standard system be subjected to all levels and types of testing including unit testing, integration testing, systems testing, functional testing, interface testing, performance testing, regression testing, and operational testing. Definitions are provided in subsection 40.3.9.

The Standard System Maintainer and the Medicare Contractor each have specific roles in testing the standard system quarterly release. Additionally, CMS contracts with an FI, Carrier, DME MAC, and CWF Host to act as a Beta tester for the FISS, MCS, VMS, and CWF systems respectively.

Effective with the January 2006 Release the CMS Single Testing Contractor (STC) will assume primary responsibility for testing the Medicare Standard Systems and CWF. The STC will be fully responsible for meeting the requirements of the Beta tester as outlined in Chapter 7, Section 40.3, including all subsections. STC interface testing with HIGLAS will be initiated in April 2006 as a shadow test on Part A. The STC shall also initiate Railroad Board (RRB) testing with the April 2006 release. Three Medicare Contractor numbers have been established to accommodate STC testing. They are 00888 for Carrier systems testing, 00388 for Fiscal Intermediary systems testing, and 44410 for DMEMAC systems testing.

This section identifies the testing responsibilities for each organization to ensure that each standard system quarterly release satisfies all CMS requirements. All organizations shall have processes in place to meet these requirements. Testing activities will generally begin 3 to 4 months in advance of the release date, particularly for standard system maintainers and the CWF maintainer.

40.3.1 – Maintainers and Beta Testers – Required Levels of Testing (Rev. 43; Issued: 03-30-07; Effective: 07-01-07; Implementation: 07-02-07)

Review subsection 40.3.9, Definitions, for a description of key testing terminology.

1. Maintainers of a Standard System or the CWF shall plan and execute all the essential levels of testing. At a minimum this includes Unit testing, Integration testing, System testing, and Regression testing. Maintainers are also responsible for performing Interface Testing.
2. Beta testers may initiate testing at the integration level, but are primarily dedicated to testing at the system level, including regression testing. Beta testers are also responsible for performing Interface Testing, which includes full data exchanges between the Standard system, CWF, and other systems (e.g., HIGLAS when implemented).
3. Maintainers and Beta testers shall maintain a test environment that enables system-testing activities to replicate the production environment, as closely as required to effectively test. CMS provided all Beta testers with a date simulation tool to facilitate executing test cases with future dates (e.g., service dates, admission dates) without turning off edits or altering effective dates in the test environment.

40.3.2 – Minimum Testing Standards for Maintainers and Beta Testers

(Rev. 43; Issued: 03-30-07; Effective: 07-01-07; Implementation: 07-02-07)

1. The Standard System Maintainer (SSM), the CWF Maintainer (CWFM), and the designated Beta tester shall fully test the quarterly release to ensure it is ready to be elevated to production. For the quarterly release to be considered fully tested, all the requirements contained within the release must be tested. Maintainers and Beta testers must be able to demonstrate the degree to which each discrete requirement within a CR has been tested and by which test cases. It is therefore mandatory that the testers maintain traceability between test cases and the discrete requirements being implemented in the release. Additionally, for each CR or transmittal under test, the Maintainer and Beta tester must ensure that each discrete requirement specified in the **Business Requirements** section of any CR/transmittal has been fully tested. The Maintainer and Beta tester shall specifically:
 - Maintain a repository of Test Requirements against which all test cases must be traced.
 - Prepare and execute a set of Test Cases that demonstrate the requirements were correctly implemented for all change requests within the quarterly release.
 - Maintain traceability between each Test Case and the requirement that the case was designed to test.
2. The Maintainer and Beta tester shall distinguish each Test Requirement with a unique Requirement Identifier. The Requirement Identifier must be a number or qualifier preceded by the CMS CR number and SSM CR number, separated by dashes. The format of the Requirement Identifier is: [SSM CR No.]-[CMS CR No.]-[Requirement No.], where:
 - SSM CR No. – is a number that identifies a CMS mandate or user change request under test. Free form text can also be used to identify changes not associated with maintainer CR numbers, e.g., “Regression” to indicate regression testing. Avoid spaces and use underscore symbol “_” instead. Dashes not allowed within this number; they are reserved for separation between the individual numbers in the Requirement Identifier.
 - CMS CR No. – is a minimum 4-digit number that identifies the CMS CR associated with the maintainer CR number. If no CMS CR is associated with a maintainer CR, use “0000”. Dashes are not allowed. Avoid spaces and use underscore symbol “_” instead. Dashes not allowed within this number; they are reserved for separation between the individual numbers in the Requirement Identifier.
 - Requirement No. – is a number that uniquely identifies the requirement with the CR. For any requirement taken from the Business Requirements section of a CMS CR, use the actual number from the Requirement # column. Do not repeat the CMS CR number. Dashes not allowed within this number; they are reserved for separation between the individual numbers in the Requirement Identifier.

Example: Maintainer CR 22522 corresponds to CMS CR 2634. Business Requirement 2.8 was taken directly from CMS CR 2634. The Requirement Identifier would be 22522-2634-2.8.

3. The Maintainer and the Beta tester shall complete Test Case specifications that include specific input situations and the expected results associated with a single test purpose. Each test case specification must include the following:
 - A unique Test Case Identifier (which includes a cross-reference to the requirement in which the case is designed to test);
 - The specific objective or purpose of the case;
 - Input specifications (i.e., a description of the input situation[s]);
 - Output specifications (i.e., a description of the expected results); and
 - Intercase dependencies - in instances where the test results of one test case may impact other test cases, the test case specification must identify the other test case(s) and describe the relationship(s).

Refer to section 40.3.10, Test Case Specification Standard, for the specific format required to electronically maintain test cases.

4. All Test Cases must contain a unique Test Case Identifier. The CMS standard for the Test Case Identifier is the Requirement Identifier, followed by a number that uniquely qualifies the test case specification, separated by a dash.

The format of the Test Case Identifier is: [Requirement Identifier]-[Test Case Number], where:

- Requirement Identifier – is the actual identifier of the requirement being testing by the case.
- Test Case Number – is a number that uniquely qualifies the test case. This is generally a sequential number. This is necessary since more than one test case is often needed to test a single requirement. Dashes not allowed within this number; they are reserved for separation between the individual numbers in the Test Case Identifier.

Example: Two test cases were developed to test the implementation of Requirement 22522-2634-2.8 (see example above). The unique Test Case Identifier for the two test cases would be 22522-2634-2.8-01 and 22522-2634-2.8-02.

5. The Maintainer and the Beta tester shall document and execute **both** positive and negative test cases to ensure the requirements of the release are correctly implemented.
 - Positive test cases are required to ensure that the system is directly fulfilling the requirements as specified. One or more positive test cases are required for each requirement. As an example, if a program mandate effects a change for services beginning on July 1, a positive test case would include service dates in July or later and validate that the actual mandate was correctly implemented.

- Negative test cases are required to ensure that the system does not perform an incorrect action. As an example, if a program mandate effects a change for services beginning on July 1, a negative test case would ensure that implementing the mandate did not negatively impact claims with service dates prior to July 1. Unlike positive test cases, a negative test case may not be applicable to every requirement within a CR. Additionally, although due diligence might necessitate a negative test case, the need may be mitigated by an existing case in your regression test set.
6. The Maintainer and Beta tester shall document all test cases and the actual results for each test case electronically. Each test case and the associated results must be stored in a test management repository (i.e., TestDirector) and must at a minimum contain the data elements outlined in the CMS Test Case specification standard. See subsection 40.3.10 for the Test Case specification standard.
 7. The Maintainer and Beta tester shall maintain a test log that provides a record of each test execution. Test Log requirements may be fulfilled by correctly using the TestDirector “run” feature as outlined in the Quarterly Release Test Management User Guide.
 8. The Maintainer and Beta tester shall execute a full regression test set on their system for every quarterly release. Each testing entity shall perform regression testing within their designated testing window as outlined in subsection 40.3.7, Timeframe Requirements.
 9. The Maintainer and Beta Tester shall perform interface testing.
 - The Maintainer and Beta Tester shall validate that all output files are correctly created by the their system. The SSM and Beta Tester shall validate that their system can accept and correctly process all input files.
 - The Standard System Maintainer and Beta Tester shall perform interface testing that includes full data exchanges (both ways) between the standard system and any principal claims processing adjudication or financial system (e.g., the CWF and HIGLAS respectively). The Beta tester is required to perform data exchanges with HIGLAS after HIGLAS is implemented at Beta tester’s data center.
 - The Standard System Maintainer and Beta tester shall complete an integrated system test with the CWF. Each Maintainer and Beta tester shall coordinate the maintenance of test data baselines, such as beneficiary data, with the CWF Beta tester.

40.3.3 – Testing Standards Applicable to all Beta Testers

(Rev. 43; Issued: 03-30-07; Effective: 07-01-07; Implementation: 07-02-07)

1. The FISS, MCS, and VMS Beta testers shall complete integrated testing with the CWF Beta tester, using coordinated beneficiary data, in the execution of their test cases. All test cases involving CWF functionality (related to claims adjudication) must be executed in an integrated test with the CWF. This requires full data exchanges between testing entities including:
 - Satellite files being sent from the standard systems to the CWF Beta tester; and

- Response files being sent from the CWF to the standard system Beta testers.
2. Each Beta tester shall:
 - Utilize the standard CMS Test Management tool and repository to documents all test cases and results.
 - Follow the procedures outlined in the Quarterly Release Test Management User Guide in order to complete the documentation of test runs and results.
 3. The Beta tester shall review all Maintainer release documentation for completeness, accuracy, and usability. Any questions, problems, or issues with the documentation shall be forwarded to both the Maintainer and CMS.
 4. The Beta Tester shall conduct performance testing to reasonably assure that the system provides acceptable response times, throughput rates, and processing windows and can accommodate production workloads.
 5. The CMS testing requirements outlined in section 40.3 may require the Beta tester to test a specific type of bill, specialty, or claim situation for which they do not possess the required level of expertise. In these instances, the Beta tester must partner with a Medicare Contractor that possesses both the expertise and capabilities to test the specialty or claim type. As an example, should a Beta tester not have the operational capability or expertise to process Home Health claims, they are expected to partner with an RHHI to complete the required HHA testing. Ultimately, the Beta tester is responsible for ensuring all test cases are exercised. Any partnerships that are established to complete the testing requirements, shall be arranged and managed by the Beta tester.

40.3.4 – Testing Requirements Applicable to the CWF Beta Tester (Rev. 43; Issued: 03-30-07; Effective: 07-01-07; Implementation: 07-02-07)

The CWF Beta tester shall act as a test host and exchange data with entities testing the FISS, MCS, and VMS standard systems. The testing entities include all standard system maintainers and the standard system Beta testers.

40.3.5 – Contractor (User) Testing Requirements (Rev. 53; Issued: 09-26-08; Effective/Implementation Date: 10-27-08)

Medicare Contractors are not mandated to prepare and execute test cases that cover Medicare business requirements implemented within the base system in standard system and CWF quarterly releases. Maintainers and Beta testers are fully responsible for testing the base functionality. The Medicare Contractors (users) shall test their local/unique components and conduct a limited, end-to-end, operational test.

1. Contractors shall fully test their local components and processing rules prior to production implementation of the quarterly release. This testing is applicable for all local components and processing rules modified since the previous quarterly release.

- A. Contractors shall test any system components they maintain and implement to support claims processing in addition to the base system. This includes front-end and back-end components such as those for EDI entry and translation, EDI outbound processing, and printing (e.g., MSN generation).
- B. Contractors shall test changes they make to user control files, facilities, and tables in order to implement new Medicare policy or business rules. Examples of these facilities include but are not limited to auto adjudication facilities (e.g., SuperOps and MCS SCF) and the MCS SPITAB.
- C. A Medicare Contractor shall fully test any standard system functionality that was:
 - Developed by the standard system maintainer solely for them, or
 - Developed by the standard system maintainer under a special project in which they were the exclusive participant.

An example would be a carrier working with CMS on a special demonstration project. In this example the carrier shall fully test the standard system functional that was implemented for the demonstration project.

- 2. Contractors shall complete a limited end-to-end operational test that incorporates the standard system release, integrated with their other claims processing components. These components include the front-end for claims receipt, translators, the CWF, the financials, and back-end EDI and report generation. The test must ensure that processing is contiguous from claims entry, to claims adjudication, and ultimately remittance and Medicare Summary Notice generation. Through contiguous processing, the interfaces between all key claims processing components must be exercised. The banking system interfaces such as National Clearing House (NCH) transfers need not be exercised. The test is limited in the number of test cases that are required, since maintainers and Beta testers are testing the base functionality of the standard system.
 - A. Contractors shall ensure that the integrated systems software can complete cycles without system abends and produce the expected output. The Medicare Contractor shall ensure their operational test:
 - Exercises all claims entry points not fully incorporated in the base system such as paper and EMC front-end components;
 - Includes all allowable standard electronic formats and versions;
 - Includes a variety of claims types; and
 - Includes all components that support their claims workload and interfaces to the standard system.
 - B. The operational test shall include the most recent standard system release received prior to the initiation of the test. The Medicare Contractor shall initiate the test as required to ensure its completion and the reporting of any problem prior to production implementation.

3. CMS strongly encourages the standard system user community to promote:
 - Standardizing their system nationally,
 - Centralizing any table maintenance that implements national Medicare policy at the system maintainer level, and
 - Minimizing local variations.
4. Medicare Contractors may perform additional testing on the standard system or duplicate Beta testing tasks as time permits. At the discretion of their Regional Offices, Medicare Contractors may be required to separately document any testing they perform in addition to their mandated testing.
5. Medicare Contractors shall test any business rule or event with future dates that they code or set-up in their Auto Adjudication Software (AAS), prior to implementing the rule or event into production. Examples of AAS include but are not limited to SuperOp, SCF, the Shack, and the Mill.
 - a. Fiscal Intermediaries and Part A/B Medicare Administrative Contractors (MACS) shall submit their date simulation recommendations to the FISS FWG in advance and participate in discussions at the FWG calls, as required to reach consensus on a date simulation schedule.
 - b. Carriers and Part A/B MACS shall submit their date simulation recommendations to the MCS FWG in advance and participate in discussions at the FWG calls, as required to reach consensus on a date simulation schedule.
 - c. DME-MACS shall submit their date simulation recommendations to the DMOP TAG in advance and participate in discussions at the DMOP TAG calls, as required to reach consensus on a date simulation schedule.
 - d. The FISS FWG, MCS FWG, and DMOP TAG shall use the “system date request process” to provide the EDC(s) their latest “run-date simulation” schedule for their FISS, MCS, and VMS UAT environments.
 - e. The FWG or DMOP TAG shall maintain their “run-date simulation” schedule for a **minimum** of 14 calendars days in advance. Here is an example of a “run-date simulation” schedule:

Calendar Date	System Run Date	Calendar Date	System Run Date	Calendar Date	System Run Date
09/08/2008	10/01/2008	09/17/2008	11/01/2008	09/26/2008	12/05/2008
09/09/2008	10/02/2008	09/18/2008	11/02/2008	09/27/2008	12/06/2008
09/10/2008	10/03/2008	09/19/2008	12/05/2008	09/28/2008	12/08/2008

09/11/2008	10/04/2008	09/20/2008	12/06/2008	09/29/2008	12/09/2008
09/12/2008	10/14/2008	09/21/2008	12/07/2008	09/30/2008	12/10/2008
09/13/2008	10/15/2008	09/22/2008	10/17/2008	10/01/2008	12/11/2008
09/14/2008	10/16/2008	09/23/2008	10/31/2008	10/02/2008	12/12/2008
09/15/2008	10/17/2008	09/24/2008	11/01/2008	10/03/2008	10/03/2008
09/16/2008	10/31/2008	09/25/2008	11/02/2008	10/04/2008	10/04/2008

- f. The FISS FWG, MCS FWG, and DMOP TAG shall provide a copy of their “run-date simulation” schedule to their CWF test host.
- g. The FISS FWG and MCS FWG shall provide a copy of their “run-date simulation” schedule to the HIGLAS test site as required to accommodate their HIGLAS enabled contractors.

40.3.6 – Testing Requirements Applicable to all CWF Data Centers (Hosts) (Rev. 53; Issued: 09-26-08; Effective/Implementation Date: 10-27-08)

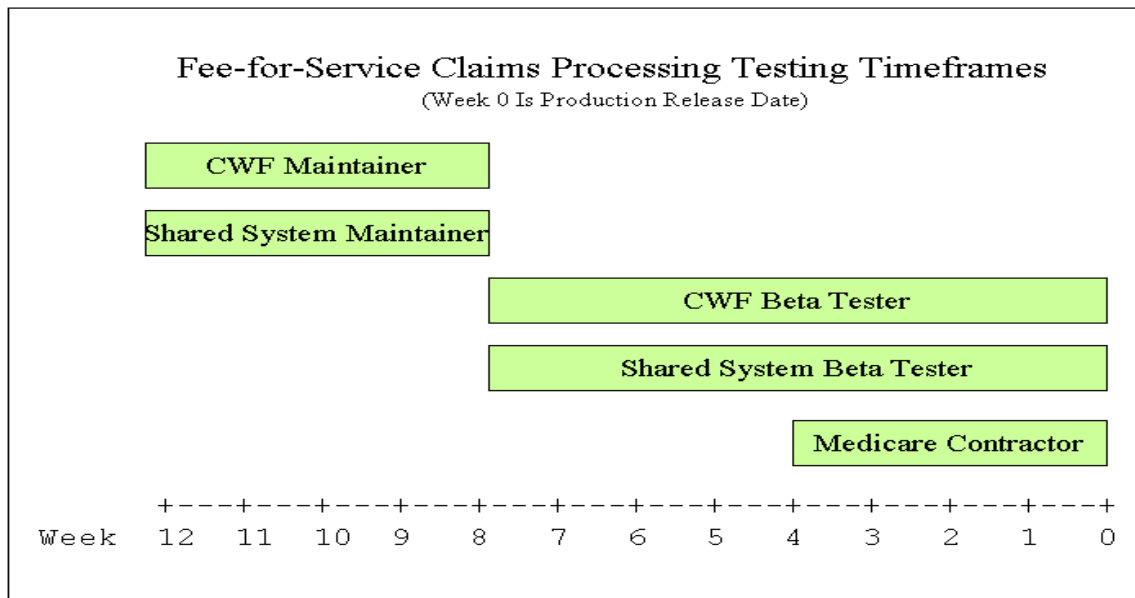
Each CWF data center or CWF sector host shall:

- Forward all satellite software and documentation to the satellites (contractors) to which they serve as the primary production host;
- Install the CWF quarterly release software in a designated test region;
- Make the designated test region available their satellites (users) for testing;
- Coordinate test data, such as beneficiary data, with the user testers;
- Process all satellite files submitted by the users and return all corresponding reply files generated for users;
- Report release problems to the CWF Maintainer and CMS;
- Verify with CMS that each of its satellites submitted at least one test file during user testing; and
- The CWF Host shall support future date testing by the FIs, Carriers, and MACs.
- The CWF Host shall review date simulation schedule submitted by the FISS FWG, MCS FWG, and DMOP TAG.

40.3.7 – Timeframe Requirements for all Testing Entities (Rev. 43; Issued: 03-30-07; Effective: 07-01-07; Implementation: 07-02-07)

The SSM, CWFM, Beta tester, and Medicare Contractor shall operate under the testing timeframes shown below for each quarterly release:

Timeframe Requirements for Testing Entities



1. The Medicare **Contractor** or **User** testing period shall begin four weeks prior to production implementation.
2. The **Beta** testing period shall begin eight weeks prior to production implementation. The CWF and standard system Beta testers shall have an exclusive four-week testing timeframe prior to the initiation of user testing.
 - The Beta tester shall complete a functional System Test and Regression Test before the standard system is released to the User community.
 - Beta testing must also continue through the User testing period. The Beta tester may initiate performance testing during the user testing period.
3. Exclusive CWFM and SSM testing shall continue until Beta testing is initiated eight weeks prior to production implementation. The SSM and CWFM shall complete a Unit Test (on all components), Integration Test, System Test, and Regression Test prior to distributing the standard system release to the designated Beta tester. For all integration, system, and regression testing, the SSM shall use the most recent version of any third party or CMS provided software components (e.g., Pricer, OCE, MCE, Grouper) they are provided. The SSM shall continue testing beyond the exclusive maintainer-testing window due to the late receipt of some third party or CMS provided software components such as the Pricers and OCE.

40.3.8 – Testing Documentation Requirements

(Rev. 43; Issued: 03-30-07; Effective: 07-01-07; Implementation: 07-02-07)

1. The SSM, Beta tester, and Medicare Contractor shall maintain documentation that fully demonstrates the requirements of this transmittal were met for each quarterly release. At a minimum the SSM, Beta tester, and Medicare Contractor shall maintain the following test documentation to demonstrate full compliance:
 - Test Requirement and Test Case repository with traceability;
 - Test Log;
 - Test Status for the execution (run) of each test case (i.e., Pass, Fail, Not Run);
 - Actual Results for the run of each test case in which the actual results did not match the expected results; and
 - Documented proof of each test run, i.e., screen shots, scheduler job logs, etc.
2. The SSM, Beta tester, and Medicare Contractor shall:
 - Maintain all test documentation for the four quarterly releases prior to the current release under test. The documentation must be available for review by CMS (or its agent).
 - Document all software defects (problems) within the CMS specified repository such as INFOMAN.
3. The SSM shall communicate all confirmed software defects (problems) and fixes directly to CMS in writing through their CMS Maintenance Lead or other designee as specified by the CMS Project Officer.
4. The Medicare Contractor shall provide any testing documentation to their CMS regional office upon request.

Additional requirements for selected standard system and CWF maintainers, Beta test sites, and CWF hosts may be contained in these organizations' individual contracts. Electronic screen shots may be incorporated/attached into the results of TestDirector has proof of online results. Test Log requirements may be fulfilled by correctly using the TestDirector “run” feature as outlined in the Quarterly Release Test Management User Guide.

40.3.9 – Definitions

(Rev. 43; Issued: 03-30-07; Effective: 07-01-07; Implementation: 07-02-07)

These definitions are provided to ensure common understanding.

Base Standard System - The FISS, MCS, VMS, or CWF system, which is routinely released by the Standard System Maintainer (i.e., Pinnacle, EDS, ViPS) to their respective user community prior to any user customization. This includes all components released by the Maintainer, including but not limited to the claim adjudication subsystem, the financial subsystems, and other integrated components (i.e., Pricer, OCE, MCE, Grouper).

Functional Testing – Testing to ensure that the functional requirements have been met.

Integration Testing – Testing combinations of interacting software components that make up parts of a system.

Interface Testing – Testing conducted to evaluate whether subsystems or systems pass data and control to one another correctly.

Local Components – A Local Component as referenced in section 40.3 is any component or module that supports Medicare claims processing, but is not part of the Base System and is under the control and maintenance of the Medicare Contractor (i.e., FI, Carrier, A/B MAC, or DMEMAC/DMERC).

Maintainer – The Maintainer is an entity to which CMS directly contracts to maintain a Medicare claim processing standard system (FISS, MCS, VMS, or NGD) or the Common Working File (CWF) system. The Maintainer, as referenced in section 40.3, does not refer to an entity to which a Medicare Contractor (Carrier, Fiscal Intermediary, or DME Regional Contractor) subcontracts to operate their data center or perform other claim processing support activities.

Operational Testing – Testing conducted to evaluate a system in its operational environment. Testing to ensure that the aggregate operational systems and their interfaces can be operated securely with the instructions provided.

Performance Testing – Testing that applies heavy transaction and processing loads to the system to ensure that response times, throughput rates, and processing windows remain acceptable and can accommodate production workloads.

Regression Testing – Testing conducted on a system or components to verify that modifications have not caused unintended effects and that the system or components still complies with its requirements.

Regression Test Set – A set of selectable test cases designed to exercise a system over its functional capabilities and assure that it still works properly after changes have been applied.

Requirement Identifier – A unique number assigned to each requirement comprised of the Standard System Maintainer CR Number, the CMS CR Number, and an alphanumeric element to uniquely qualify each requirement. For testing purposes CMS requires that each Test Case Identifier incorporate the Requirement Identifier to which it is traced.

Stress Testing – Testing that applies a steadily increasing load to the system until it reaches the point where performance degrades to unacceptable levels.

System Testing – Testing to discover any incorrect implementation of the requirements or incompatibilities in the software/hardware environment. System testing includes functional testing, performance testing, and operational testing.

Test Case Specification – A description of an input situation and of the required results associated with a specific test objective or purpose.

Test Case Identifier – A unique identifier assigned to each test case.

Test Log – A chronological record of relevant detail about the execution of tests. Relevant details include run date, run time, test status, and actual results.

Test Requirement - A specific requirement that is under test and to which one or more test cases are traced. Test requirements may be derived from various types of requirements i.e., business functional requirements, performance requirements etc. Note: Any well-written requirement that is “testable” may be considered a Test Requirement. Any requirement contained in the Business Requirements section of a CR or transmittal, also constitutes a test requirement.

Test Set – A collection of test cases that have a common usage.

Unit Testing – The testing of individual units (i.e., software components, modules) or groups of related units. It is the lowest level of testing and is usually performed by programmers. Unit testing may be both functional (requirements oriented) and structural (i.e. logic oriented, code coverage oriented).

40.3.10 - Test Case Specification Standard **(Rev. 6, 05-28-04)**

Purpose: This standard establishes a controlled outline for the contents and presentation of a Test Case Specification used by the standard system maintainers and the Beta testing contractors.

Applicability: This standard is applicable to all Test Case Specifications developed by the standard system maintainers and the Beta testing contractors.

Data Element	Description	Allowable Values or Format	Comments
Test Case Specification Identifier	Multi-part indicator that uniquely identifies the test case specification.	See Test Case Specification Identifier Standard.	
Test Purpose	A free form field that captures the intent of the test and identifies any key components of the test, e.g., specific codes.	See attached example.	

Input Specification	<p>A free form field that captures critical information used to exercise the system functionality. Information could be grouped into the following topics:</p> <p>Claim Data Requirements</p> <p>Claims History</p> <p>Beneficiary Information</p> <p>Provider Information</p>	See attached example.	
InterCase Dependencies (Predecessor Transaction Identifier)	The test case specification identifier of the transaction that must be entered into and processed by the system prior to processing the transaction described by the test case specification.	See Test Case Specification Identifier Standard.	
Output Specification	A free form declarative statement that identifies the expected results from performing all the steps, as a collection, within the test.		
Test Type	A one-character indicator to identify whether the test is positive or negative.	P = Positive Test N = Negative Test	TestDirector Plan Tab (Required User Defined Fields)
Originator	A one-character indicator to identify the originating entity (designer) of the test case.	B = Beta C = CMS/QRTM M = Maintainer	
Test Status	Summary indicator for a test case.	PS = Passed FA= Failed NR = Not Run IN = Incomplete ID = Invalid Data IC = Invalid Case	Required Test Execution (Run) Elements

Test Results	Free form declarative statement of actual results for a test case when the actual results do not match the expected results.		
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Optional Information: Industry best practices demonstrate that additional granularity may be necessary to document discrete key test actions that should be executed and documented. These items are referred to as test steps. A test case specification may have one or more test steps. When documenting test steps, the following standard applies:

Step Number	Unique identifier for each test step.	<p>“Step n”</p> <p>Where “n” is a sequential counter for each step starting at 1.</p> <p>There is at least one test step in each test case specification, but usually contains multiple test steps.</p>	Optional Test Case Elements
Step Description	A free form declarative statement that identifies the action taken to perform the test. The step description statement usually begins with a verb.		
Expected Step Results	A free form declarative statement that identifies the expected results from performing the associated step description.		

Example #1

Test Case Identifier		4393-2342-12.1-001
Test Purpose		To confirm that the FI claims processing systems accept, process and assign a reason code to Hospital claims with services denied based on a Local Medical Review Policy (LMRP) submitted on Type of Bill (TOB) 141 (Hospital other or referred diagnostic services; admit through discharge), generating Medicare Summary Notice (MSN) message 15.20 (The following policies were used when we made this decision) auto-filling LMRP identification (ID) number L481 (Breast Imaging; Mammography/Breast Echography [Sonography]/Breast) associated with the edit for each fully denied service.
Input Specification	Claims History	Mammography service previously rendered and paid \leq 11 months
	Beneficiary Information	Beneficiary has elected English as primary language. Female Age: \geq 40
	Provider Information	Provider Number Range: XX0001 - XX0999
	Claim Data Requirements	TOB: 141 (Hospital other or referred diagnostic services; admit through discharge) Revenue Code #1: 403 (Other imaging services; screening mammography) Units #1: 1 HCPCS Code #1: 76091 (Mammography; bilateral) Revenue Code #2: 403 (Other imaging services; screening mammography) Units #2: 1 HCPCS Code #2: 76092 (Screening mammography; bilateral [two view film study of each breast]) Diagnosis Code: V76.12 (Other screening mammography)
Intercase Dependencies		None
Output Specification		Claim will be assigned a reason code indicating services denied based on LMRP ID# L481, generating MSN message 15.20.
Test Type		P
Originator		C
Test Status		PS
Test Results		Claim was assigned appropriate reason code

Example #2

Test Case Identifier		4419-2825-5.2-001
Test Purpose		To confirm that the FI claims processing systems accept, process, and assign reason code 30 (Payment adjusted because the patient has not met the required eligibility, spend down, waiting or residency requirements) to Inpatient Hospital claims submitted on Type of bill (TOB) 111 (Hospital Inpatient Part A; admit through discharge) with Dates of Service (DOS) on 01/01/2004 when a beneficiary is not lawfully present in the United States.
Input Specification	Claims History	None
	Beneficiary Information	Beneficiary must be unlawfully present in United States. Beneficiary elected English as primary language
	Provider Information	Provider Number Range = XX0001-XX0999
	Claim Data Requirements	TOB = 111 DOS = 01/01/2004
Intercase Dependencies		None
Output Specification		Claim will be assigned reason code 30 indicating beneficiary is not lawfully present in the United States, generating MSN message 5.7 (Medicare payment may not be made for the item or service because on the date of service, you were not lawfully present in the United States).
Test Type		P
Originator		C
Test Status		PS
Test Results		Claim was assigned appropriate reason code

40.3.11 - Next Generation Desktop (NGD) Maintainer Requirements

(Rev. 25, Issued: 07-15-05, Effective: 08-15-05, Implementation: 08-15-05)

CMS is continuing to fully deploy the Next Generation Desktop (NGD) to the contractors' beneficiary customer service departments. The NGD is a single call center application that will be used by Medicare Customer Service Representatives (CSRs) to answer inquiries and perform operations on behalf of CMS beneficiaries and the American public.

The NGD is designed to pull customer service-needed information into a common desktop application. As such, the NGD requires data exchange with CMS shared systems (VMS, CWF, FISS, MCS) and standard systems (EDB/MBD, MBR, GHP/MMCS). Note: NGD may integrate with additional systems as future releases are developed.

Because NGD integrates with the shared systems, periodic changes will be made as a result of the shared systems quarterly release process. The NGD maintainer will be required to update NGD as part of either a service pack or a patch to the system. The NGD maintainer will be required to perform the various activities associated with changes to the NGD (i.e., unit and system testing). In addition to the shared systems quarterly release schedule, the NGD will adhere to a separate quarterly release process for NGD-specific updates and defect correction.

The NGD maintainer shall follow all of the requirements identified in Section 40.3 for the shared system maintainers except as indicated below:

1. Section 40.3.1 Maintainers and Beta Testers –Required Levels of Testing, #3 is not applicable to NGD Beta testers.

2. Section 40.3.2 (#2) Minimum Testing Standards for Maintainers and Beta Testers, for NGD naming conventions, the NGD Maintainer should refer to the NGD test Plan.

3. Section 40.3.2 (#4) Minimum Testing Standards for Maintainers and Beta Testers, for NGD test case identifiers, the NGD maintainer should refer to the NGD System Test Plan.

4. Section 40.3.7 Timeframe Requirements for Testing Entities – NGD testing timeframes are as follows:

- The NGD User testing period shall begin 2 weeks prior to production implementation.
- The NGD Beta testing period shall begin 4 weeks prior to production implementation. The NDG Beta testers shall have an exclusive 2 week testing timeframe prior to the initiation of user testing.
 - The Beta tester shall complete a functional System Test and Regression Test before the system is released to the User community.
 - Beta testing must also continue through the User testing period.
- Exclusive NGD System Maintainer testing shall continue until Beta testing is initiated 4 weeks prior to production implementation. The NGD Maintainer shall complete a Unit Test (on all components), Integration Test, System Test, and Regression Test prior to distributing the shared system release to the designated Beta Tester.

5. Section 40.3.8 Testing Documentation Requirements (#2) For NGD, documentation of all software defects (problems) should be through ClearQuest.

50 – Review of Contractor Implementation of Change Requests

(Rev. 66, Issued: 01-07-11, Effective: 02-08-11, Implementation: 02-08-11)

POLICY

The contractors must implement Change Requests (CRs). The CMS expects contractors to implement 100% of all issued CRs. A CMS Central Office (CO) representative will send, on a quarterly basis, a CR Implementation Report (which includes a Details page, a Summary page and a sample Cover Letter/Attestation Statement – see sections 50.1, 50.2 and 50.3), as well as instructions for completing and submitting the CR Implementation Report, to all contractors . This report will contain all CRs to be implemented within that fiscal quarter. When a CR includes “For Analysis Only” in its title, the CR is for analysis only by shared system maintainers to conduct further review. Contractors are not required to implement the CR until further notification. Therefore, “For Analysis Only” CRs will not be included in the CR Implementation Report. The CO representative will send the reports to the contractors within 1 week of the end of the fiscal quarter. The contractors shall enter all applicable information into the reports and send the completed reports to the CMS CO mailbox no later than the 28th of the month in which the reports are due. If the report due date of the 28th falls on a weekend or a holiday, each contractor, including MACs, shall submit the report on the next business day following the due date. Each MAC shall also send a copy of the report to its respective deliverables mailbox or to the CMS ART system, pending direction from the MAC Project Officer.

Each contractor, by contractor number, shall complete one CR Implementation Report (which includes a Summary page, a Details page, a Cover Letter/Attestation Statement, and, if necessary, a separate explanation document that is no longer than one page for each CR; this explanation document would explain, for example, why the CR was not implemented at all or not implemented timely). An electronic mailbox has been established at the CO to receive the quarterly reports.

- Quarter 1 includes October, November and December. The report for Quarter 1 is due no later than February 28th.
- Quarter 2 includes January, February and March. The report for Quarter 2 is due no later than May 28th.
- Quarter 3 includes April, May and June. The report for Quarter 3 is due no later than August 28th.
- Quarter 4 includes July, August and September. The report for Quarter 4 is due no later than November 28th.

In addition, each contractor shall write and maintain written procedures on its change management process (i.e., Standard Operating Procedures – SOP). Elements should include, but are not limited to, written procedures for the timely downloading of CMS instructions (issued CRs) from the CMS DRIMAILBOX, written procedures of the contractor’s CR distribution process (including, but not limited to, the dissemination of provider education information), written procedures for CR implementation (including written documentation to verify CR implementation).

Contractors shall retain the written documentation to verify CR implementation using CMS’s records retention guidelines.

Upon request from CMS, contractors shall supply the written procedures of their change management process, as well as written documentation to verify CR implementation to CMS.

Implementation Date

I. Definition

Refer to section 50.4.2 of this chapter for the definition of the implementation date.

II. Supporting Information

For any instruction affecting providers, regardless if there are systems or non-systems changes, CMS gives at least 90 days' advance notice to the providers. That is, CMS must issue the instruction at least 90 days prior to the implementation date to give providers enough time to implement the instruction. The vehicle used to alert providers 90 days prior to an instruction's implementation date is the CMS Quarterly Provider Update, which can be accessed at: http://www.cms.hhs.gov/QuarterlyProviderUpdates/01_Overview.asp

There are four exceptions to the 90 days' advance notice policy: (1) the instruction is contractor specific and therefore does not affect providers; (2) the instruction is a correction/clarification where the previously issued instruction contained typos or errors of fact or omissions; (3) the instruction is a routine or recurring item (which qualifies it to be included on the Mid-Quarter List in the Provider Update); and (4) the instruction is approved by the CMS Administrator to be published immediately or by a certain date.

For a system change, the initiator of the CR will specify an implementation date that corresponds to one of the quarterly release dates. Usually, the quarterly release date will be the first Monday of the quarter. On occasion, an off-cycle release date can be approved by OSORA and/or the Administrator. This exception tends to occur most frequently with the implementation of National Coverage Determinations (NCDs).

For a non-system change that has no impact on providers, the initiator of the CR may specify the implementation date as: 30 days from issuance, 45 days from issuance, 60 days from issuance, and on occasion 14 days from issuance. In some rare situations, the implementation date may be specified as "upon issuance."

After the comment period ends and the initiator of the CR has addressed all comments, he/she prepares a final CR package for CMS clearance. The last part of the CMS clearance process involves obtaining approval from the Medicare Change Control Board (MCCB). The MCCB, in consultation with the initiator of the CR, will determine the time period needed for implementing each change request. After the clearance process is completed, the Office of Strategic Operations and Regulatory Affairs/Issuances & Records Management Group (OSORA/IRMG) will insert the actual implementation date before issuing the CR as a final instruction.

COMPLETING AND SUBMITTING THE QUARTERLY CR IMPLEMENTATION REPORT

1. Intermediaries, Carriers, RHHIs, A/B MACs and DME MACs (here on referred to as contractors) shall complete Items 1 through 17 of the CR Implementation Report, as

necessary, for each contractor number. [The exceptions are Item 5, which is pre-filled by CMS, and Items 7 and 11, which are automatically calculated by the spreadsheet. Items 1 through 11 are located on the Summary page (see section 50.1), and items 12 through 17 are located on the Details page (see section 50.2).

2. Item 1: Contractors shall enter the “Contractor Name” in Item 1 of the report. [Item 1 is on the Summary page of the spreadsheet.]
3. Item 2: Contractors shall enter “Contractor #” in Item 2 of the report. [Item 2 is on the Summary page of the spreadsheet.]
4. Item 3: Contractors shall enter the “Date Report Submitted to CMS” in Item 3 of the report in MM/DD/CCYY format. [This is the date the report is e-mailed to CMS CO.] [Item 3 is on the Summary page of the spreadsheet.]
5. Item 4: Contractors shall enter the name and telephone number of the “Contractor Certifying Official” in Item 4 of the report. [The Contractor Certifying Official shall be a contractor employee with management authority. The Contractor Certifying Official shall not be a staff person who simply completes the report.] [Item 4 is on the Summary page of the spreadsheet.]
6. Item 5: Contractors shall not enter any information in Item 5 of the report, as it has been pre-filled by CMS.
7. Item 6: Contractors shall enter the # of CRs added by the contractor, if any, in Item 6 of the report. [This action may be necessary should CMS inadvertently omit a CR that should have been included in the report.] [Item 6 is on the Summary page of the spreadsheet.]
8. Contractors shall enter the number zero in Item 6 of the report if no CRs are being added to the report.
9. Item 7: Contractors shall not enter any information in Item 7 of the report, since Item 7 is automatically calculated by the spreadsheet.
10. Item 8: Contractors shall enter the # CRs implemented by CMS Published Impl. Date in Item 8 of the report. [See “Implementation Date” definition in the Policy section.] [Item 8 is on the Summary page of the spreadsheet.]
11. Item 9: Contractors shall enter the # CRs implemented after CMS Published Impl. Date in Item 9 of the report. [See “Implementation Date” definition in the Policy section.] [Item 9 is on the Summary page of the spreadsheet.]
12. When a contractor receives from CMS a waiver for a CR, the contractor shall enter the comment “approved waiver” and the waiver number (in the following format: “DB-xxx” in Item 14 of the report. [The waiver number is the tracking number CMS assigns to the waiver. It is located in the upper left section of the waiver letter.] Also, please note that there are no waivers for MACs regarding the implementation of CRs.

13. When a contractor requests from CMS a waiver for a CR, and to date has not received an approval or denial from CMS for the waiver, the contractor shall enter the comment “pending waiver” and the date of the waiver request (in MM/DD/CCYY format) in Item 14 of the report.
14. Item 9.1: Contractors shall enter the total # CRs that have an approved waiver or are pending a waiver in Item 9.1 of the report. [This is the total # of “approved waiver” and “pending waiver” entries from Item 14 of the report.] [Item 9.1 is on the Summary page of the spreadsheet.]
15. Item 10: Contractors shall enter the # of CRs that are not applicable (N/A) to their contractor operations in Item 10 of the report. [This is the total # of “N/A” entries from Item 13 of the report.] [Item 10 is on the Summary page of the spreadsheet.]
16. Item 11: Contractors shall not enter any information in Item 11 of the report, since Item 11 is automatically calculated by the spreadsheet.
17. Contractors shall ensure that Item 7 equals Item 11 by entering correct numbers in Items 6, 8, 9, 9.1 and 10.
18. Item 12: Contractors shall enter the “Contractor Actual Implementation Date” in MM/DD/CCYY format in Item 12 of the report. [This is the date the contractor actually implemented the CR. See “Implementation Date” definition in the Policy section.] [Item 12 is on the Details page of the spreadsheet.]
19. Item 13: Contractors shall enter “N/A” in Item 13 of the report if the CR is not applicable to their contractor operations. Otherwise, leave Item 13 blank. [Item 13 is on the Details page of the spreadsheet.]
20. Item 14: Contractors shall enter “Comments/Brief Reason for Delay in Implementation” in Item 14 of the report. [Please limit comments to approximately 100 characters.] [Item 14 is on the Details page of the spreadsheet.] If comments exceed 100 characters, the contractors shall submit with the completed CR Implementation report a separate explanation document, no longer than one page, for each CR that is not implemented by the CMS Published Implementation Date.
21. Item 15: Contractors shall not enter any information in Item 15 of the report, as this is for CMS Internal Use Only.
22. Item 16: Contractors shall not enter any information in Item 16 of the report, as this is for CMS Internal Use Only.
23. Item 17: Contractors should add CRs they think should have been listed on the CR Implementation Report in Item 17 – Additions. [Item 17 is on the Details page of the spreadsheet.]
24. Each contractor who adds a CR to the CR Implementation Report shall enter all necessary information for the additional CR, which includes the following: CMS Transmittal #, CMS CR #, Subject, the fiscal quarter (QTR) and fiscal year (FY) the CR is to be implemented,

the CMS Published Implementation Date (in MM/DD/CCYY format) and complete Items 1 through 17, as necessary.

25. Each contractor, by contractor number, shall prepare a Cover Letter/Attestation Statement attesting that all instructions required to be implemented within the quarter have been implemented. Each contractor should use the Sample Cover Letter/Attestation Statement that is outlined in section 50.3. At a minimum, each contractor shall include in the Cover Letter/Attestation Statement the following information: Contractor Name, Contractor Number, Date Report Submitted to CMS, Subject, Attention, a statement that the Contractor Certifying Official attests that all instructions required to be implemented during the quarter have been implemented, with exceptions noted in Item 14 of the report or attached separately if the comment exceeds 100 characters, and the name and title of the Contractor Certifying Official.
26. Each contractor, including MACs, shall, by contractor number, submit, via e-mail and by the report due date, one completed CR Implementation Report (which includes a Summary Page, a Details Page, a Cover Letter/Attestation Statement, and, if necessary, a separate explanation document that is no longer than one page for each CR) to the CMS CO mailbox. [The CMS CO mailbox is: CR_IMPL_REPORTS@cms.hhs.gov. NOTE: There are no spaces in this web address. Underscore “_” separates the words CR_IMPL_REPORTS.] If the report due date of the 28th falls on a weekend or a holiday, each contractor, including MACs, shall submit the report on the next business day following the due date.
27. Each MAC shall also send a copy of the report to its respective deliverables mailbox or to the CMS ART system, pending direction from their MAC Project Officer.

50.1 – CR Implementation Report – Summary Page (Rev. 52; Issued; 07-11-08; Effective/Implementation: 08-11-08)

	Required Information:	Enter Your Responses Below:
Item [1]	Contractor Name:	
Item [2]	Contractor #:	
Item [3]	Date Report Submitted to CMS: MM/DD/CCYY	
Item [4]	Contractor Certifying Official & Telephone #:	
Item [5]	# of CRs CMS included in this report:	
Item [6]	# CRs added by the contractor (from Item 17 of Details page):	
Item [7]	Auto Sum - Total of Items 5 and 6 (# of CRs CMS included in this report + # of CRs added by the contractor):	0

Item [8]	# CRs implemented by CMS Published Impl. Date:	
Item [9]	# CRs implemented after CMS Published Impl. Date:	
Item [9.1]	# CRs approved or pending a waiver (from Item 14 of Details page):	
Item [10]	# CRs that are not applicable (N/A) to your contractor operations (from Item 13 of Details page):	
Item [11]	Auto Sum - Total of Items 8, 9, 9.1 and 10. This total must equal the total calculated in Item 7.	0
	<p>Quarter 1 - Oct Nov Dec (report due no later than February 28th)</p> <p>Quarter 2 - Jan Feb Mar (report due no later than May 28th)</p> <p>Quarter 3 - Apr May Jun (report due no later than August 28th)</p> <p>Quarter 4 - Jul Aug Sep (report due no later than November 28th)</p>	
	Fiscal Year	

50.2 – CR Implementation Report – Details Page

(Rev. 17, Issued 02-25-05, Effective: 03-01-05, Implementation: 03-01-05)

No.	CMS Transmittal #	CMS CR #	Subject	QTR	FY	CMS Published Impl. Date: MM/DD/CCYY
1						
2						

3						
“”						

				For CMS Internal Use Only	For CMS Internal Use Only
	Item [12]	Item [13]	Item [14]	Item [15]	Item [16]
No.	Contractor Actual Impl. Date: MM/DD/CCYY	Enter "N/A" if CR is not applicable to your contractor operations	Comments/Brief Reason for Delay in Implementation	Waiver Requested	Walkthrough / Early Involvement. Call
1					
2					
3					
“”					

Item [17]	Additions
A1	
A2	
A3	
“”	

50.3 – CR Implementation Report – Sample Cover Letter/Attestation Statement

(Rev. 52; Issued; 07-11-08; Effective/Implementation: 08-11-08)

Contractor Name:

Contractor Number:

Date Report Submitted to CMS: [MM/DD/CCYY]

Subject: Attestation Statement: Implementation of Change Requests, Qtr.__, FY__ [Include the appropriate quarter and fiscal year in the Subject line.]

Attention: CMS Central Office (CO) Medicare Contractor Management Group (MCMG)

In accordance with the Centers for Medicare & Medicaid Services (CMS) Change Requests 2884 and 6102, I attest that all instructions required to be implemented within Quarter __ [1, 2, 3 or 4 – select appropriate quarter] of FY __ [Enter appropriate fiscal year.] have been implemented. Exceptions are explained in Item14 of the Details page of the CR Implementation Report or attached if the explanation exceeds 100 characters.

Sincerely,

[Name of Contractor Certifying Official.]

[Title of Contractor Certifying Official.]

50.4 – Change Request (CR) Definitions

(Rev. 66, Issued: 01-07-11, Effective: 02-08-11, Implementation: 02-08-11)

50.4.1 – Issue Date

(Rev. 66, Issued: 01-07-11, Effective: 02-08-11, Implementation: 02-08-11)

The date the Centers for Medicare and Medicaid Services (CMS) publishes a change request (CR).

When a CR has passed through all phases of the change management process, it is then ready for publication; that is, the CMS is ready to make the instructions contained in the CR available to contractors, maintainers, providers, beneficiaries and/or any group or organization that may be affected, as appropriate. The CMS publishes CRs by posting them as Transmittals, on the CMS Web site.

Note: The issue date is named “Date” on the Transmittal form, One-Time Notification, Recurring Update Notification, and the Standard CR forms. It is sometimes referred to as the “transmittal date.”

50.4.2 – Implementation Date

(Rev. 66, Issued: 01-07-11, Effective: 02-08-11, Implementation: 02-08-11)

The implementation date identified in a change request (CR) is the date by which Medicare fee-for-service contractors and shared system maintainers shall apply all changes detailed in the business requirements, unless otherwise specified. It is the date when all necessary updates to infrastructure, business processes and/or supporting technology changes shall be completed and operational in order to execute new/modified policy and procedure.

For CRs that do not require changes to the shared systems (non-system changes), contractors are usually given 30 to 90 days from issuance to implement the CR.

For CRs that do require changes to the shared systems (system changes), a date is specified that usually corresponds with one of the quarterly shared system release dates. The date is usually the first Monday of the quarter (for example, January 3, April 4, July 5, or October 3 for 2011).

Unless otherwise stated, the implementation date is the same for all business requirements listed within a specific CR. In some instances, a separate implementation date(s) may be given for a particular business requirement(s) within a CR.

Implementation and effective dates are frequently not the same. The list below contains the scenarios for the differences:

- The effective date and implementation date are different because the first day of the quarter is not a Monday;*
- The effective date and the implementation date are different because the effective date occurs after the implementation date;*
- The effective date and the implementation date are different because the effective date occurs before the implementation date, but both dates are in the future; or*
- The effective date and the implementation date are different because the effective date occurs before the implementation date, and the effective date is in the past, while the implementation date is in the future.*

50.4.3 – Effective Date

(Rev. 66, Issued: 01-07-11, Effective: 02-08-11, Implementation: 02-08-11)

The effective date identified in a change request (CR) is the date on which any new rules, laws, processes and/or policies become active.

Beginning on this date, Medicare contractors shall apply the new rules to process Medicare claims according to their updated business processes and supporting technology.

The effective date is normally a mandated date resulting from legislation or a regulation. In the case of National Coverage Determinations (NCDs), the effective date is the first day the item or service that is the subject of the NCD is covered nationally under the Medicare Program.

Effective dates are not always future dates; sometimes, they are in the past. When this happens, the Centers for Medicare and Medicaid Services (CMS) instructs contractors, using business requirements, how to process claims for the period between the effective date and the implementation date. Typically, the effective date is the first day of any given fiscal year quarter or the first day of the month.

50.4.4 – Date of Service

(Rev. 66, Issued: 01-07-11, Effective: 02-08-11, Implementation: 02-08-11)

The date of service (DOS) is the date a provider renders service to a beneficiary. Unless otherwise specified, the effective date of a change request is the date of service.

For the purpose of processing claims, the effective date for applying processing rules, laws, processes, and/or policies is the date the beneficiary received a service from a provider. For Durable Medical Equipment (DME) claims with spanned dates of service, the ViPS Medicare System (VMS) will use only the “From” DOS as the date the supplier rendered a service to a beneficiary. For example, if a new rule or law became effective on January 1, 2011, and a beneficiary received service on December 27, 2010, then that service would not be covered under the new rule. If the beneficiary received the service on or after January 1, 2011, then that service would be covered by the new rule.

More service-specific information on the Date of Service can be found in. Pub.100-02, Medicare Benefit Policy Manual and Pub. 100-04, Medicare Claims Processing Manual.

60 – Procedures for Modifying Shared System Edits and Capturing Audit Trail Data

(Rev. 23, Issued: 05-06-05; Effective: 10-01-05; Implementation: 10-03-05)

POLICY

Contractors must implement processes and procedures for adding, deleting, inactivating, bypassing or otherwise modifying all shared system edits. Contractors must also have the capability to document and track those modifications. Modifications to maintainer coded edits must additionally include documentation that provides the rationale for the modification, the expected duration of the change, the impact of the change with respect to potential over or underpayments, claims volumes, affect on providers and / or beneficiaries, etc. In addition, the claims operations manager or equivalent area manager must document approval of the edit modification followed by CMS approval before any maintainer coded edit change has been made.

Intermediaries and carriers shall examine their current processes for modifying shared system edits and adjust them to incorporate the appropriate levels of internal controls. These controls must be documented and available upon request for review by CMS or an auditor. In addition,

contractors must limit the number of personnel with the security clearance to modify maintainer coded shared system edits to ten (10).

Should the reason for an edit modification be because of a shared system deficiency, that associated problem must be documented and reported to the maintainer by the contractor. The shared system maintainer and contractor must prioritize the appropriate systems changes to correct edit deficiencies and schedule them for correction as soon as possible via existing change management processes. Should there not be consensus with the contractors regarding schedule, CMS maintenance staff should be consulted.

Shared system maintainers must have the capability to track edit changes made by a contractor to the maintainer coded shared system edits. The shared systems must be able to identify who modified the edit, what was modified and when the alteration was made.

60.1 – CMS Standard File for Reason Codes

(Rev. 59, Issued: 10-30-09, Effective: 04-01-10, Implementation: 04-05-10)

The FI Edits Evaluation Workgroup is tasked with identifying the inventory of contractor inactivated edits, documenting the reasons why the edits are turned off, and making a decision as to whether they should remain inactive or not. Transmittal 338, (Change Request (CR) 5927) issued on May 2, 2008, created the ‘CMS Standard’ field within the existing FISS Reason Code File which contains the status that was determined by the FI Edits Evaluation Workgroup for each individual code that was reviewed. The ‘CMS Standard’ field indicators are as follows:

- ‘A’ = Active
- ‘I’ = Inactive
- ‘ ’ = Blank

NOTE: The terms ‘Active’ & ‘Inactive’ are defined as:

- Active = Reason code status is equal to ‘S’, ‘P’, ‘ ’ (blank), ‘D’, ‘R’, ‘T’, or is not equal to ‘S MDLTD’; and
- Inactive = Reason code status is equal to ‘A’ or is equal to ‘S MDLTD.’

Each quarter, as necessary, CMS will issue an updated CMS Standard File for Reason Codes which is loaded into the system by the FISS maintainer via a Recurring Update Notification.

70 – Change Management Process -- Electronic Change Information Management Portal (eChimp)

(Rev. 34, Issued: 01-06-06, Effective Date: on or after 01-03-06, Implementation Dates: on or after 01-03-06)

The Centers for Medicare & Medicaid Services’ (CMS’s) Division of Change Management (DCM) is responsible for the coordination and distribution of the draft Medicare Fee-for-Service (FFS) Change Requests (CRs) for Point-of-Contact (POC) Review. To that end, the DCM has developed the Electronic Change Information Management Portal (eChimp), a user-friendly, Web-based application to streamline and automate the change management process.

In September 2004, the initiators of the CRs began creating and submitting CRs to the DCM via eChimp. In the past, the DCM distributed the draft Medicare FFS CRs to only 15 contractor POCs and shared system maintainers (SSMs) for POC review. The SSMs forwarded the CRs to their users for review which increased the time to market the CR and sometimes resulted in the submission of late comments. Therefore, beginning January 3, 2006, the DCM will continue to notify the CMS and SSM POCs of the draft Medicare FFS CRs that are in POC review and also notify all the Medicare FFS contractor POCs as well via eChimp 2.0. The DCM will implement eChimp 2.0 on a voluntary basis for its internal CMS staff. Initiators of CRs may create and submit a CR for POC review using eChimp 2.0 beginning January 3, 2006. However, effective February 6, 2006, eChimp 2.0 will be implemented on a mandatory basis (i.e., all CRs will be initiated, submitted and reviewed in eChimp 2.0). The POCs will continue to receive the POC Review e-mail for CRs initiated and submitted in eChimp 1.0 which will contain the CR and the attachments until February 6, 2006. In addition to receiving the POC review e-mail with the CR and the attachments, POCs will also receive the POC review e-mail alert for CRs that are initiated and submitted in eChimp 2.0 which will not contain the CR file and the attachments. However, these e-mail alerts will contain a link for the POCs to click to review and submit comments on the CR via eChimp 2.0.

NOTE: Beginning February 6, 2006, contractors and maintainers should not reply to any e-mails from eChimp@cms.hhs.gov nor should they send any e-mail to eChimp@cms.hhs.gov. Effective February 6, 2006, we will not accept any e-mails sent to that address.

The notification of the draft Medicare FFS CRs will be distributed via an E-mail from eChimp to the CMS, contractor and SSM POCs, which will no longer contain the files and documents associated with the draft CR. Once the POCs receive the e-mail notification from eChimp that notifies them that a CR is currently in POC review, they shall log in to eChimp via a link that will be provided in the E-mail notification. Once logged in, they shall review the draft CR and provide comments to CMS via eChimp by the POC Review Comment due date. To maintain as much efficiency as possible with such a large number of prospective reviewers, each POC may submit only one set of comments on behalf of their contractor or maintainer organization and that submission must be identified as such. If the CR impacts Part A, Part B, DME and/or RHHI and it makes more sense to submit the comments separately (to keep the content clear), then two sets of comments from the contractor site or maintainer organization will be acceptable. No response received will be considered a concurrence. NOTE: It is the responsibility of the POCs to notify appropriate staff that a CR has entered POC review and to share the information with them. Each individual who has access to eChimp will also have the ability to review, download and print the CR files and share the files, either electronically or hardcopy, with other staff members who do not have eChimp access.

We believe that expanding the POC review process to all of the Medicare FFS contractors and SSMs will not only decrease the time to market the CRs, but will also increase the quality of the review of the CRs by allowing a wider audience of those potentially impacted by the change the opportunity to comment. We also believe that this expansion to the POC review process will reduce the number of late comments submitted as well as reduce the number of corrected CRs now necessary as a result of uncoordinated and/or untimely POC comments.

CMS realizes that expanding the POC review process to all of the Medicare FFS contractors and SSMs could potentially cause a lack of efficiency and an administrative burden if the above-outlined POC review process is not adhered to. Therefore, we will pilot this expanded POC

review process for approximately 3 months effective February 6, 2006. At the conclusion of the 3 months, we will evaluate the pilot and adjust the POC review process, if necessary.

80 - Fee-for-Service Contractor Workload Transitions

(Rev. 44, Issued: 05-25-07, Effective: 01-04-06, Implementation: 07-02-07)

Fee-for-Service contractor workload transitions occur when: 1) a Medicare carrier or fiscal intermediary's Title XVIII contract is either non-renewed or is terminated; or 2) a Medicare Administrative Contractor's (MAC) period of performance ends or its contract is terminated. When either of these two circumstances occurs, the outgoing contractor must work with the new incoming contractor to transfer the Medicare workload without any disruption to providers and beneficiaries.

During a transition, the outgoing contractor has responsibilities and processes for closing out its Medicare contract and shutting down its operation. It must also assist the new incoming contractor in its efforts to assume the Medicare claims administration functions. Concurrently, the incoming contractor must establish an operational infrastructure and ensure that all data, records, and functions are properly transferred from the outgoing contractor. Both parties have a responsibility to ensure that the transition is conducted seamlessly and that all contractual obligations are met during the transition.

80.1 - Transition Handbooks

(Rev. 44, Issued: 05-25-07, Effective: 01-04-06, Implementation: 07-02-07)

The Medicare Contractor Management Group (MCMG) in the Center for Medicare Management has developed handbooks in order to assist fee-for-service contractors with the transfer of Medicare workload from one contractor to another. There are two basic handbooks: one for incoming contractors (workload implementation handbook) and one for outgoing contractors (workload closeout handbook).

Every Medicare workload transition will vary depending on the unique circumstances and environment of the Medicare contractors involved. There may be activities and processes described in the handbooks that, for various reasons, will not be applicable to a specific transition. There may also be activities that will need to be performed that the handbooks do not cover. The handbooks cannot identify and address all of the variations that may occur during a workload transition. However, the overall activities described in the handbooks for managing a workload implementation or closeout project and the requirements contained therein for meetings, reporting, and providing information, data, and records are part of the IOM and incorporated by reference into the carrier, fiscal intermediary, and MAC contracts.

80.1.1 - Workload Implementation Handbook

(Rev. 44, Issued: 05-25-07, Effective: 01-04-06, Implementation: 07-02-07)

The workload implementation handbook has two versions: the Medicare Administrative Contractor Workload Implementation Handbook, which is found on the CMS Web site at: <http://www.cms.hhs.gov/MedicareContractingReform/Downloads/MACImplementationHandbook.pdf>, and the Durable Medical Equipment Medicare Administrative Contractor Workload Implementation Handbook, which is found at:

http://www.cms.hhs.gov/MedicareContractingReform/Downloads/DME_MAC_Implementation_Handbook.pdf

The handbooks describe the basic responsibilities and processes necessary for an incoming contractor to establish an infrastructure, obtain resources, communicate with project stakeholders, and transfer the outgoing contractor's Medicare files and data.

Both handbooks consist of 14 chapters and 9 exhibits as discussed below:

1. Chapter 1: Introduction provides an introduction to the handbook and the goals for a successful workload transition.
2. Chapter 2: CMS Organization provides information on the duties and responsibilities of CMS's transition oversight staff.
3. Chapter 3: Getting Started describes the activities that are necessary to start the implementation process. It discusses establishment of the implementation team, kickoff meetings, and the organization and function of transition workgroups. The chapter also addresses initial notification activities.
4. Chapter 4: Implementation Management discusses the approach that a MAC may take for the implementation project. It includes the assessment of the outgoing contractor's Medicare operation and a discussion on information and deliverables required from the carrier/intermediary.
5. Chapter 5: Obtaining Resources and Establishing Infrastructure provides helpful information about personnel and facilities preparation. The chapter also covers hardware/software and telecommunication requirements, data center information, and electronic data interchange (EDI).
6. Chapter 6: Transfer of Carrier/Intermediary Operations describes the activities associated with moving the actual workload and Medicare functions from the carrier/intermediary, DMERC, or MAC. This includes analyzing the various functional areas, file transfer activities, asset inventory, and miscellaneous operational considerations.
7. Chapter 7: Interaction with Other Transition Organizations discusses the major organizations with which the MAC will work during the implementation and the basic responsibilities of each.
8. Chapter 8: Testing discusses the establishment of a test plan. It also describes the various tests that the MAC can perform in order to ensure that it will be able to process claims and perform its Medicare functions.
9. Chapter 9: Cutover covers the actual migration of records, files, and data (both physically and electronically) to the MAC, as well as any resources and infrastructure. The chapter also provides information on cutover plans, system dark days, and the reduction of the payment floor.
10. Chapter 10: Post-Cutover describes the activities that occur after cutover, including workload reporting and lessons learned.

11. Chapter 11: CMS Monitoring Requirements provides information on the various meetings that are necessary during a transition. It also describes the reporting requirements so that CMS may monitor the MAC's implementation progress.

12. Chapter 12: Communications discusses the approach and tasks associated with providing information about the transition to all direct and indirect stakeholders in the transition. This includes providers, beneficiaries, trading partners, medical and specialty groups, government officials, advocacy groups, and other interested parties.

13. Chapter 13: Financial Processes provides information on the financial activities required to move the Medicare workload. It discusses cash management and banking tasks, the accounts receivable reconciliation, and 1099 issues. There is also a section that provides information on vouching protocols.

14. Chapter 14: Risk Management discusses risk management processes including risk assessment, risk mitigation, and contingency plans.

15. Exhibits:

Exhibit 1	Transition Phases and Terminology
Exhibit 2	MAC Contract Administrative Structure
Exhibit 3	Major Tasks and Activities Associated with a Workload Transition
Exhibit 4	Outgoing Contractor Information/Documentation
Exhibit 5	Files to be Transferred to a Medicare Administrative Contractor
Exhibit 6	Sample Workload Report
Exhibit 7	MAC Workload Implementation Meeting and Documentation Guide
Exhibit 8	Glossary
Exhibit 9	Abbreviations

80.1.2 - Workload Closeout Handbook

(Rev. 44, Issued: 05-25-07, Effective: 01-04-06, Implementation: 07-02-07)

There are two versions of the workload closeout handbook: the Carrier/Intermediary Workload Closeout Handbook, found on the CMS Web site at:

http://www.cms.hhs.gov/MedicareContractingReform/Downloads/CI_Closeout.pdf, and the Durable Medical Equipment Regional Carrier Workload Closeout Handbook, found at: http://www.cms.hhs.gov/MedicareContractingReform/Downloads/Outgoing_DMERC_Handbook.pdf.

The handbooks describe the basic responsibilities and procedures for a carrier or intermediary to close out its Medicare contract activities and to assist an incoming contractor in its efforts to assume Medicare claims administration functions. While the handbooks are written specifically for Title XVIII Medicare carriers and fiscal intermediaries, they could be of use to a Medicare Administrative Contractor should its contract be ending.

The workload closeout handbook consists of 8 chapters and 10 exhibits as discussed below:

1. Chapter 1: Introduction provides an introduction to the handbook and the goals for a successful workload transition.
2. Chapter 2: CMS Organization provides information on the duties and responsibilities of CMS's transition oversight staff.
3. Chapter 3: Initial Closeout Activities describes the activities that are necessary to start the contract closeout process. It discusses establishment of the closeout project team, project kickoff meetings, and the organization and function of transition workgroups. The chapter also addresses initial notification activities.
4. Chapter 4: Project Management discusses the various tasks necessary to manage the closeout process. This includes developing the Closeout Project Plan, the use of consultants, interaction with the incoming MAC, communications, and meeting and reporting requirements.
5. Chapter 5: Personnel and Infrastructure provides information on personnel issues and CMS policy on retention bonuses and severance pay. It also discusses policy on terminating subcontracts, asset inventory and disposition, and security.
6. Chapter 6: Closeout Operations and Providing Information/Assistance discusses the approach that a carrier/intermediary may take for its closeout operations and the type of information that should be provided to assist the MAC in its implementation. It also covers file transfer activities and assisting the MAC in its communication efforts.
7. Chapter 7: Cutover and Post-Cutover Activities covers the activities associated with final preparations for the operational closeout and the migration of records, files, and data. In addition, the chapter provides information on cutover plans, system dark days, lessons learned, and post-cutover reporting.
8. Chapter 8: Financial Processes provides information on the development of closeout costs and the financial activities required to move the Medicare workload. It discusses the development of transition and termination costs, banking activities, the accounts receivable reconciliation, audits, and 1099 responsibilities.
9. Exhibits:
 - Exhibit 1 Transition Phases and Terminology
 - Exhibit 2 MAC Contract Administrative Structure
 - Exhibit 3 Financial Memorandum to Outgoing Contactors

Exhibit 4	Sample Closeout Project Plan
Exhibit 5	Outgoing Contractor Information/Documentation
Exhibit 6	Files to be Transferred to a Medicare Administrative Contractor
Exhibit 7	Workload Closeout Meetings and Documentation
Exhibit 8	Sample Workload Report
Exhibit 9	Sample Staffing Report
Exhibit 10	Glossary

90 – Integrated Data Repository (IDR) Claims Sourcing from Shared Systems (Rev. 54, Issued: 10-01-08; Effective: 10-01-08; Implementation: 01-05-09)

The CMS' fraud investigation landscape is significantly different today than in the past as a result of program changes, such as the implementation of the Medicare Prescription Drug benefit, competitive selection of contractors responsible for claims administration and program integrity, such as Medicare Administrative Contractors (MACs) and PSCs, expansion of Medi-Medi and Recovery Audit Contractor (RAC) programs, and advent of the Medicaid Integrity Program (MIP). CMS recognizes the need to significantly enhance the use of technology to improve its collaborative fraud fighting efforts as well as to establish a modernized data analysis capability for all of Program Integrity.

Today, most Program Integrity contractors have built their own data warehouses and/or avenues for collecting, processing, analyzing data which serves their own individual needs. These distributed, regional approaches to data analysis do not lend themselves to national analyses, do not represent best practices, and do not take advantage of the cost savings that a centralized data repository would provide. All of these functions can be better served through a comprehensive set of common data structures and modern tools that encourage collaboration and innovation.

The IDR goal – through incremental releases – is to be the centralized data repository for all Medicare data. The Program Safeguard Contractors (PSCs) cannot currently use the IDR exclusively because the source of claims data is the National Claims History (NCH). The limited NCH data record is inadequate to support the extensive fraud, waste and abuse investigations that need to be performed by PSCs. The Shared Systems data are the required data source for Program Integrity. The CR initiates the acquisition of the Shared Systems data for the IDR. Once the IDR has the required Shared Systems data, Program Integrity and their contractors will increase their ability to detect potential fraud, waste and abuse.

FISS shall provide, in electronic format, all claims output for all FIs and claim types on a daily basis at the claims header and detail level for each of the three identified lifecycle phases required.

MCS shall provide, in electronic format, all claims output for all Carriers and claim types on a daily basis at the claims header and detail level for each of the three identified lifecycle phases required.

VMS shall provide, in electronic format, all claims output for all DMEMACs and Certificates of Medical Necessity, as required with certain claims for payment, on a daily basis at the claims header and detail level for each of the three lifecycle phases required.

The IDR Lifecycle Phase I is defined as the claim upon enumeration. The IDR Lifecycle Phase II is defined as the claim immediately after CWF adjudication. The IDR Lifecycle Phase III is defined as the claim once financial information has been posted to it.

Transmittals Issued for this Chapter

Rev #	Issue Date	Subject	Impl Date	CR#
<u>R66GI</u>	01/07/2011	Change Request (CR) Definitions	02/08/2011	6592
<u>R59GI</u>	10/30/2009	The CMS Standard File for Reason Codes for the Fiscal Intermediary Shared System (FISS)	04/05/2010	6529
<u>R57GI</u>	02/20/2009	Implementing Validated Workarounds for Share System Claims Processing by Medicare Administrative Contractors (A/B MACs), Durable Medical Equipment Medicare Administrative Contractors (DMEMACs), Carriers, Regional Home Health Intermediaries (RHHIs) and Fiscal Intermediaries	03/20/2009	6379
<u>R54GI</u>	10/01/2008	IDR Claims Sourcing From Shared Systems-Implementation	01/05/2009	5949
<u>R53GI</u>	09/26/2008	Medicare Contractor Testing with Future Dates in the EDC	10/27/2008	6110
<u>R52GI</u>	07/11/2008	Change to CR Implementation Report Due Dates	08/11/2008	6102
<u>R51GI</u>	05/16/2008	IDR Claims Sourcing From Shared Systems-Implementation - Rescinded and Replaced by Transmittal 54	10/06/2008	5949
<u>R46GI</u>	07/20/2007	Implement New Contractor ID for Single Testing Contractor (STC)	01/07/2008	5648
<u>R44GI</u>	05/25/2007	Fee-for-Service Contractor Transition Handbooks	07/02/2007	5446
<u>R43GI</u>	03/30/2007	Clarification in Testing Instructions for Definition of "Local Components"	07/02/2007	5395
<u>R38GI</u>	05/26/2006	Files Maintenance Program Update to the Internet-Only Manual (IOM)	06/26/2006	5055
<u>R34GI</u>	01/06/2006	Change Management Process -- Electronic Change Information Management Portal (eChimp)	01/03/2006	4092
<u>R33GI</u>	12/30/2005	Change Management Process -- Electronic Change Information	01/03/2006	4092

		Management Portal (eChimp)		
<u>R30GI</u>	10/28/2005	Initiate STC testing of the MCS for RRB and HIGLAS	04/03/2006	4150
<u>R26GI</u>	07/22/2005	Implement New Medicare Plan ID and Carrier Number for the Single Testing Contractor (STC)	10/03/2005	3978
<u>R25GI</u>	07/15/2005	Next Generation Desktop (NGD) Testing Requirements	08/15/2005	3493
<u>R24GI</u>	05/27/2005	2005 Scheduled Release for July Updates to Software Programs and Pricing/Coding Files	06/27/2005	3865
<u>R23GI</u>	05/06/2005	Procedures for Modifying Shared Systems Edits and Capturing Audit Trail Data	10/03/2005	3862
<u>R17GI</u>	02/25/2005	Review of Contractor Implementation of Change Requests (Replacement for expired CR 944)	03/01/2005	2884
<u>R16GI</u>	01/28/2005	Standard Terminology for Claims Processing Systems	04/04/2005	3596
<u>R15GI</u>	01/21/2005	Review of Contractor Implementation of Change Requests (Replacement for expired CR 944)	03/01/2005	2884
<u>R08GI</u>	07/30/2004	Establish Standard Terminology for Medicare Shared Systems	01/03/2005	3086
<u>R06GI</u>	05/2//2004	CMS Policy for Testing Quarterly Release of the Medicare Shared Systems and the CWF	08/01/2004	3011
<u>R05GI</u>	05/07/2004	Initial Publication of Chapter	N/A	2765

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